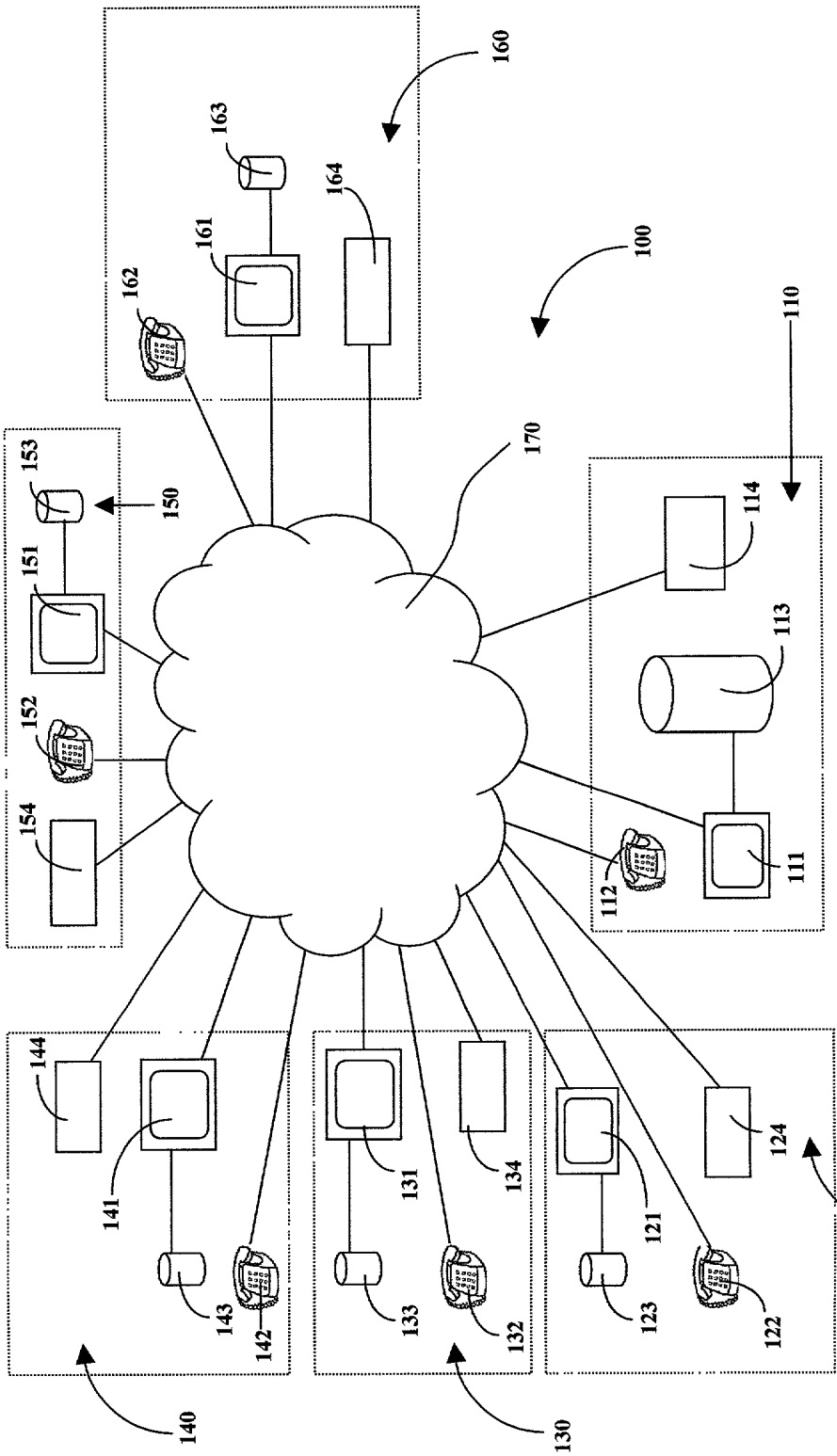
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Fig. 1

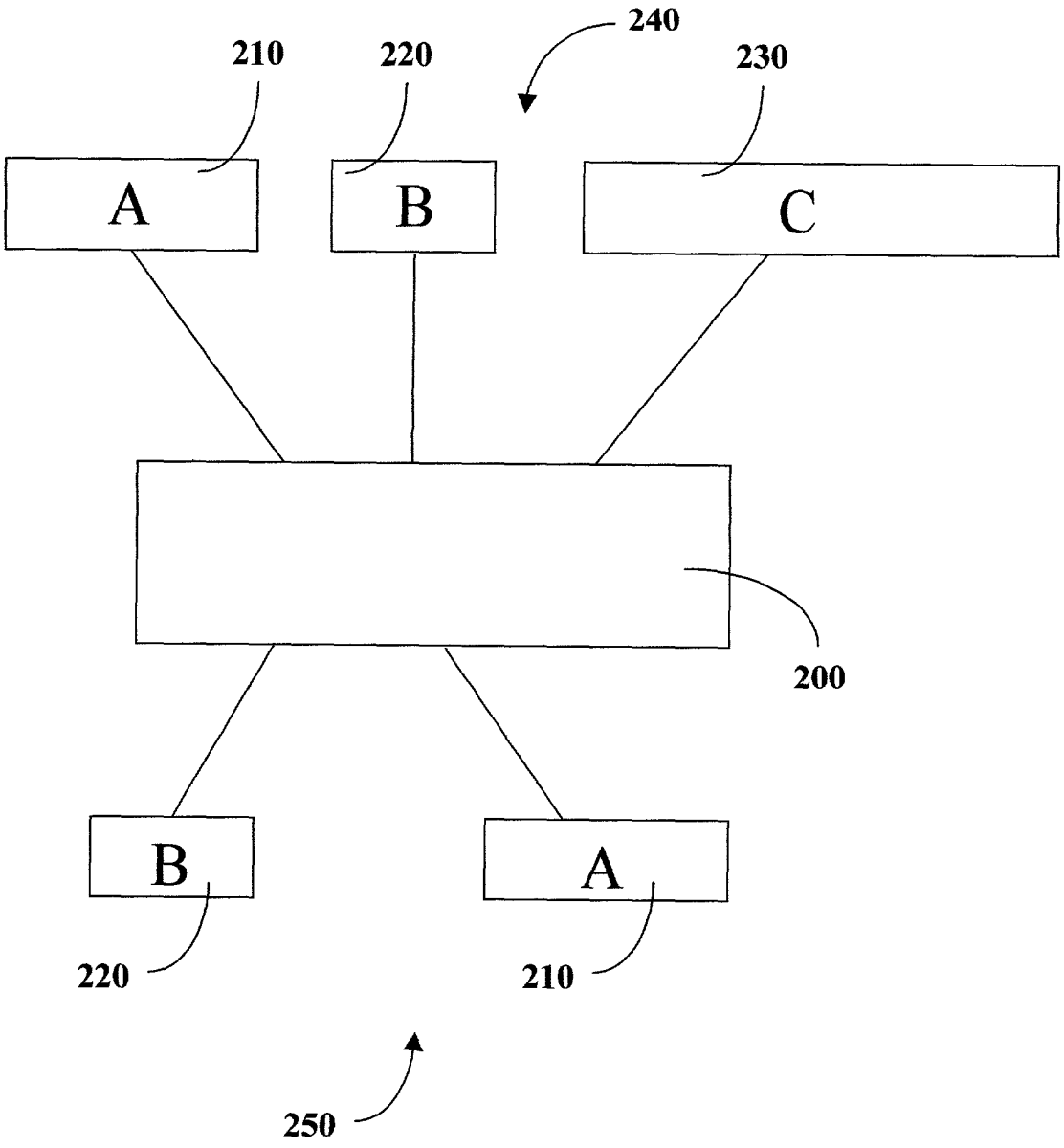

Fig. 2

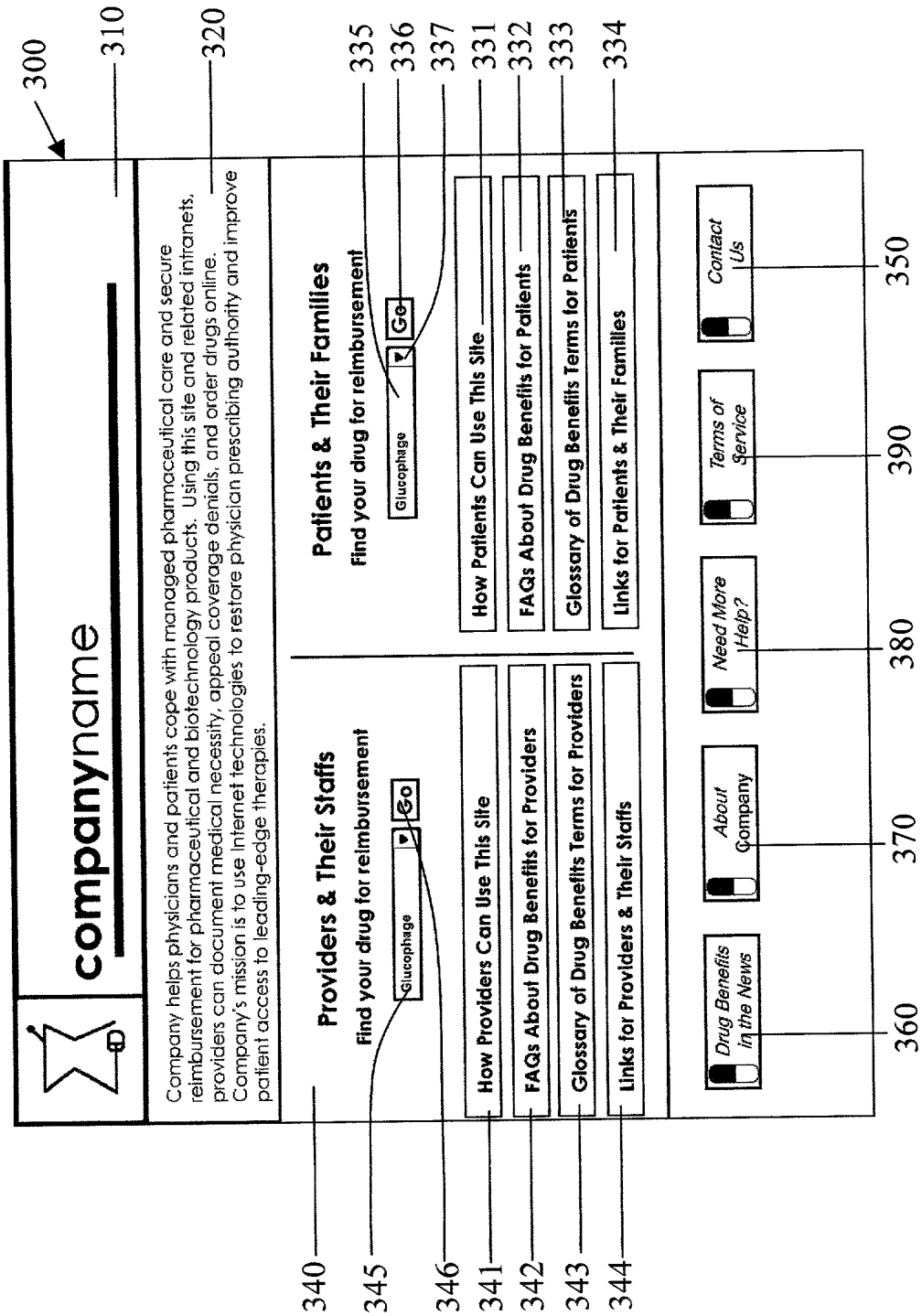
300
310
320
companyname
Company helps physicians and patients cope with managed pharmaceutical care and secure reimbursement for pharmaceutical and biotechnology products. Using this site and related intranets, providers can document medical necessity, appeal coverage denials, and order drugs online. Company's mission is to use Internet technologies to restore physician prescribing authority and improve patient access to leading-edge therapies.
Providers & Their Staffs
Find your drug for reimbursement
Glucophage
Go
How Providers Can Use This Site
FAQs About Drug Benefits for Providers
Glossary of Drug Benefits Terms for Providers
Links for Providers & Their Staffs
Patients & Their Families
Find your drug for reimbursement
Glucophage
Go
How Patients Can Use This Site
FAQs About Drug Benefits for Patients
Glossary of Drug Benefits Terms for Patients
Links for Patients & Their Families
Drug Benefits in the News
About Company
Need More Help?
Terms of Service
Contact Us
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Fig. 3

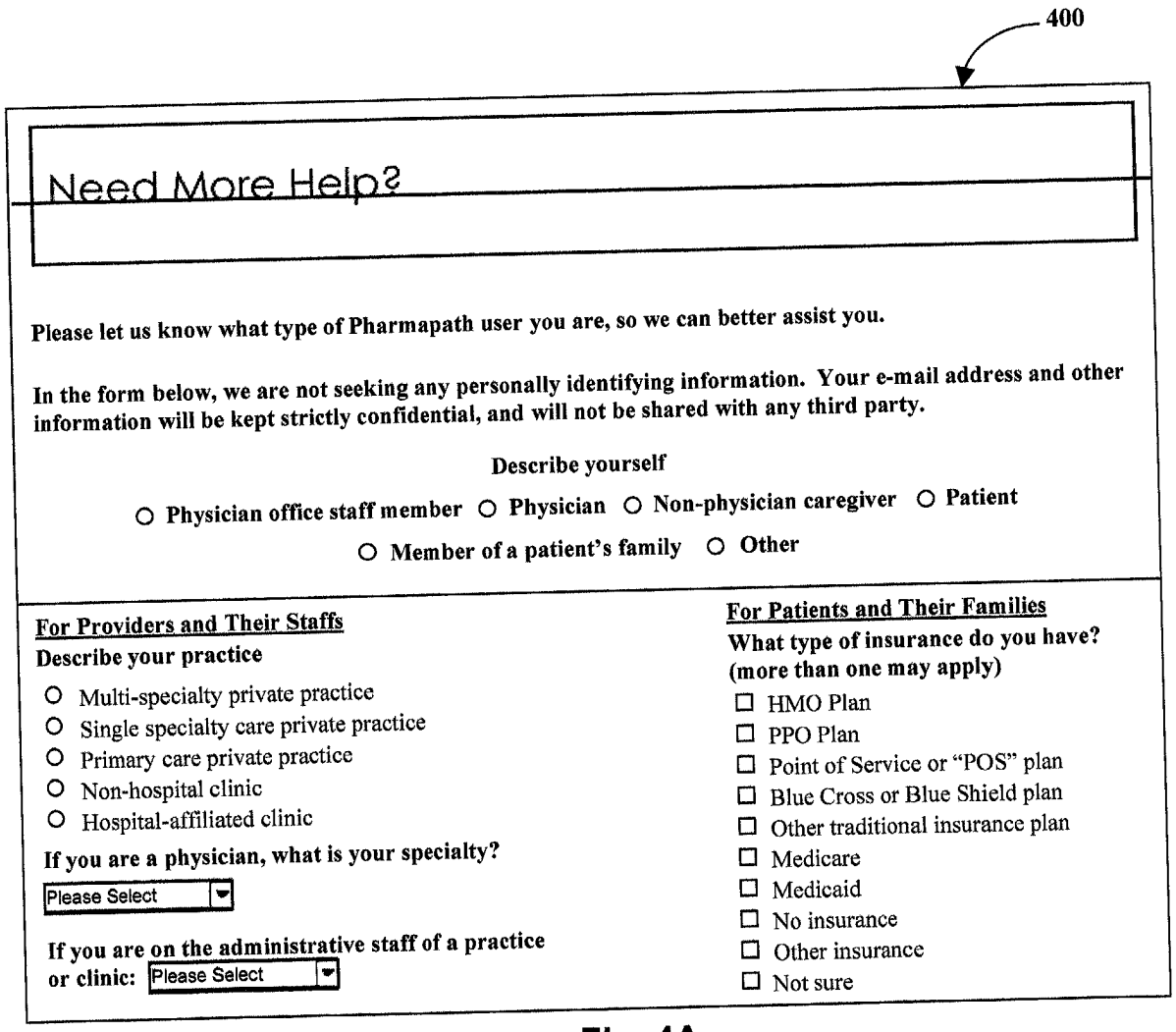


Fig. 4A

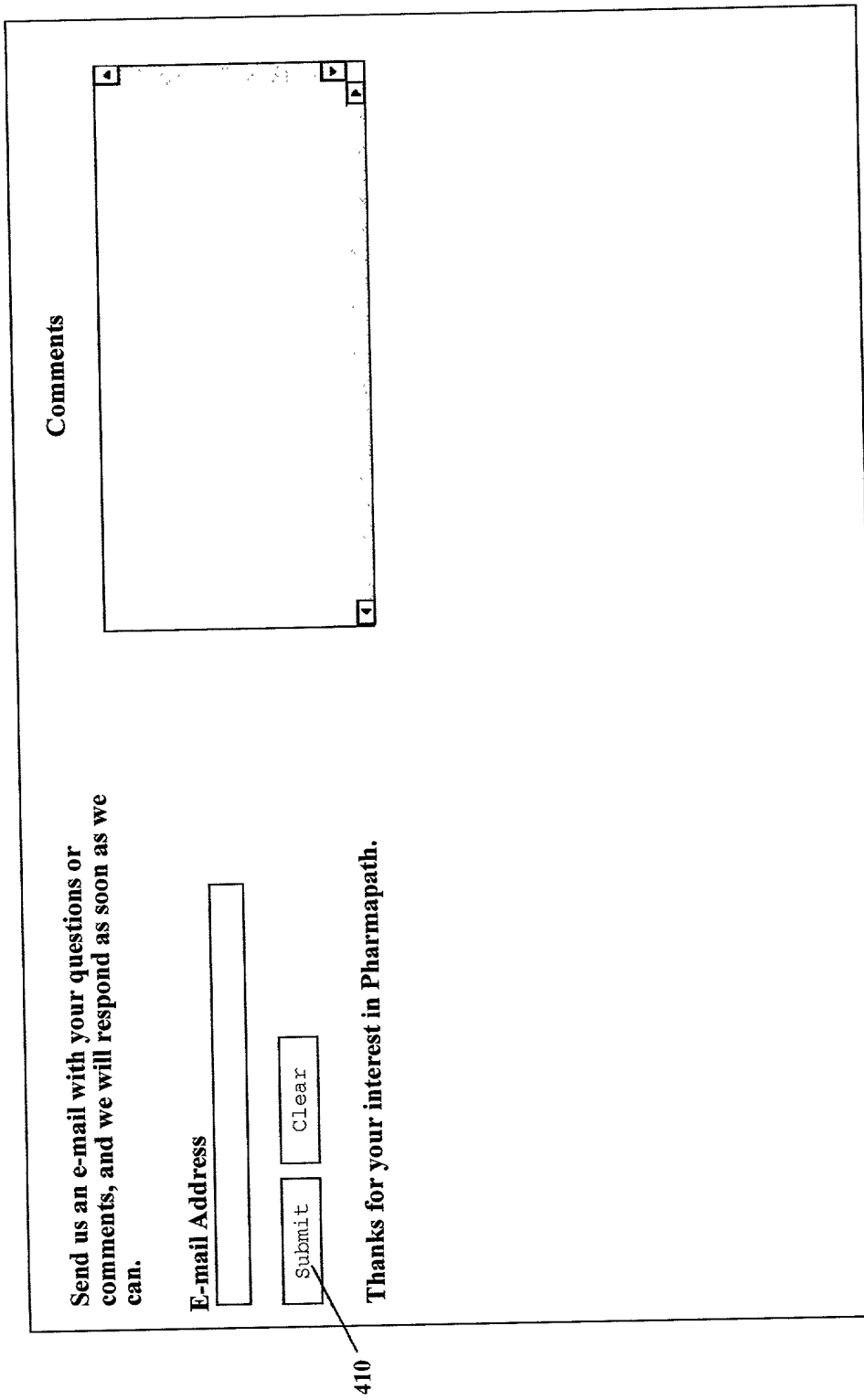

Comments
Send us an e-mail with your questions or comments, and we will respond as soon as we can.
E-mail Address
Submit
Clear
Thanks for your interest in Pharmapath.
410

Fig. 4B

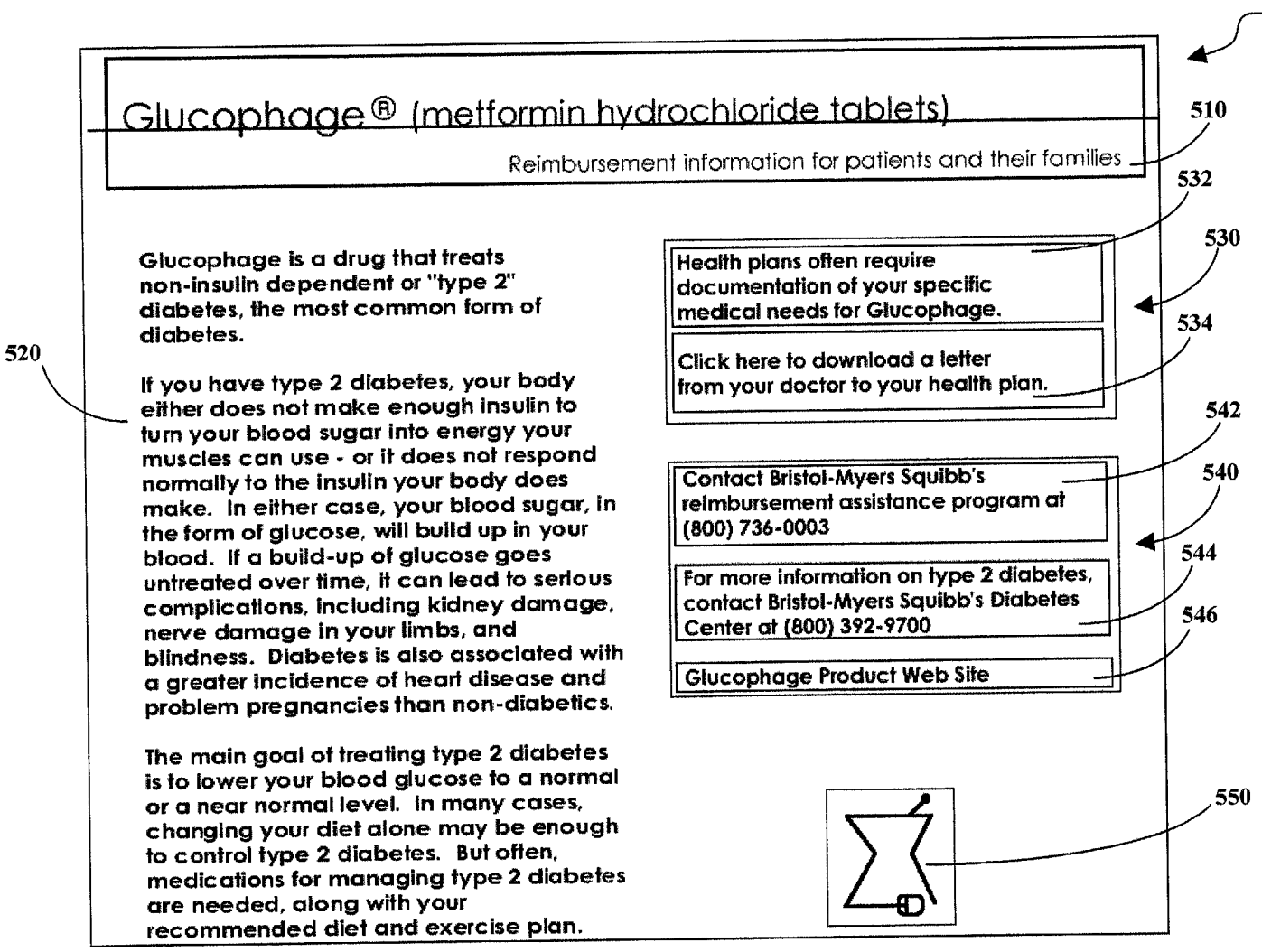


Fig. 5A

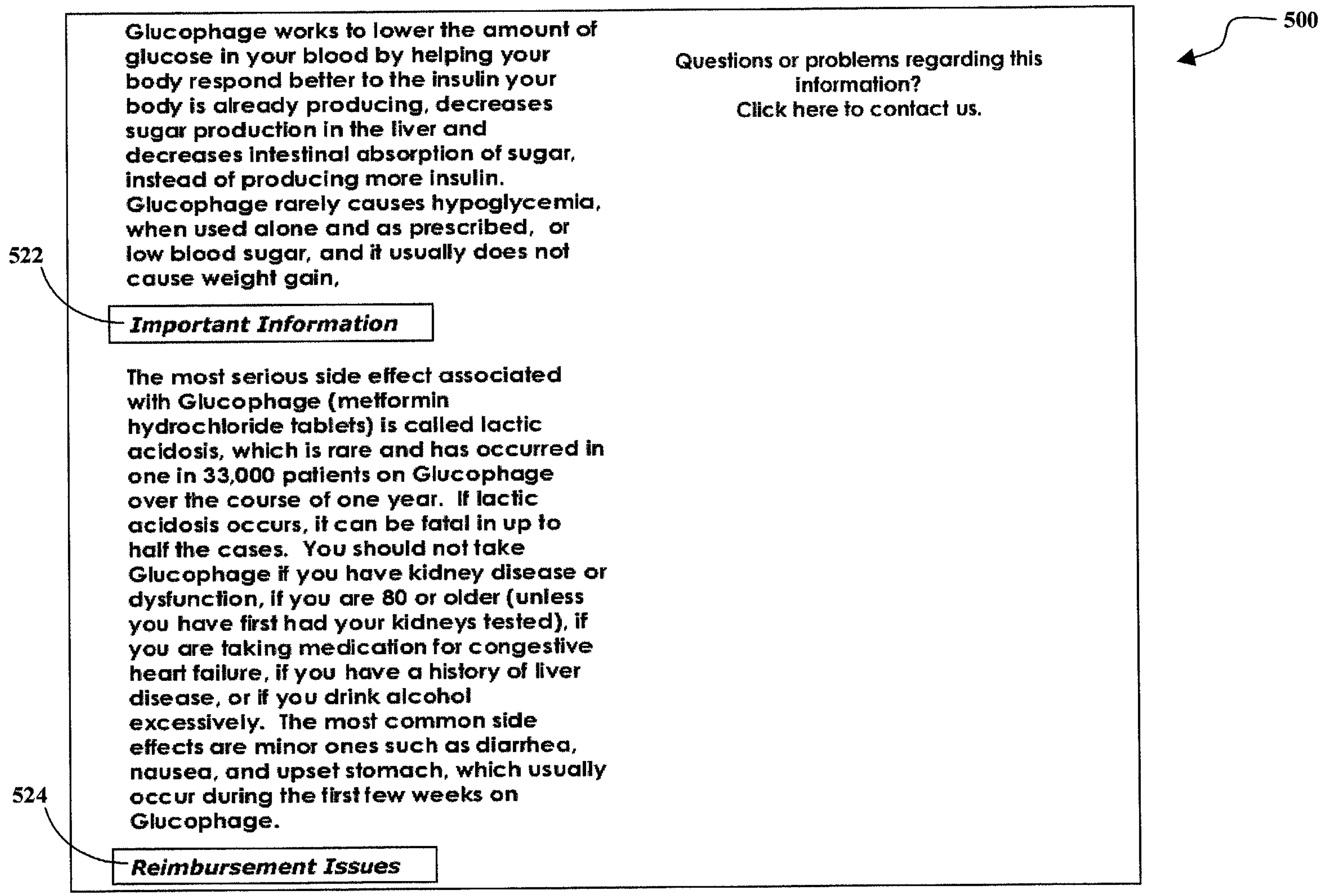

500
Glucophage works to lower the amount of glucose in your blood by helping your body respond better to the insulin your body is already producing, decreases sugar production in the liver and decreases intestinal absorption of sugar, instead of producing more insulin. Glucophage rarely causes hypoglycemia, when used alone and as prescribed, or low blood sugar, and it usually does not cause weight gain,
522
Important Information
The most serious side effect associated with Glucophage (metformin hydrochloride tablets) is called lactic acidosis, which is rare and has occurred in one in 33,000 patients on Glucophage over the course of one year. If lactic acidosis occurs, it can be fatal in up to half the cases. You should not take Glucophage if you have kidney disease or dysfunction, if you are 80 or older (unless you have first had your kidneys tested), if you are taking medication for congestive heart failure, if you have a history of liver disease, or if you drink alcohol excessively. The most common side effects are minor ones such as diarrhea, nausea, and upset stomach, which usually occur during the first few weeks on Glucophage.
524
Reimbursement Issues
Questions or problems regarding this information?
Click here to contact us.

Fig. 5B

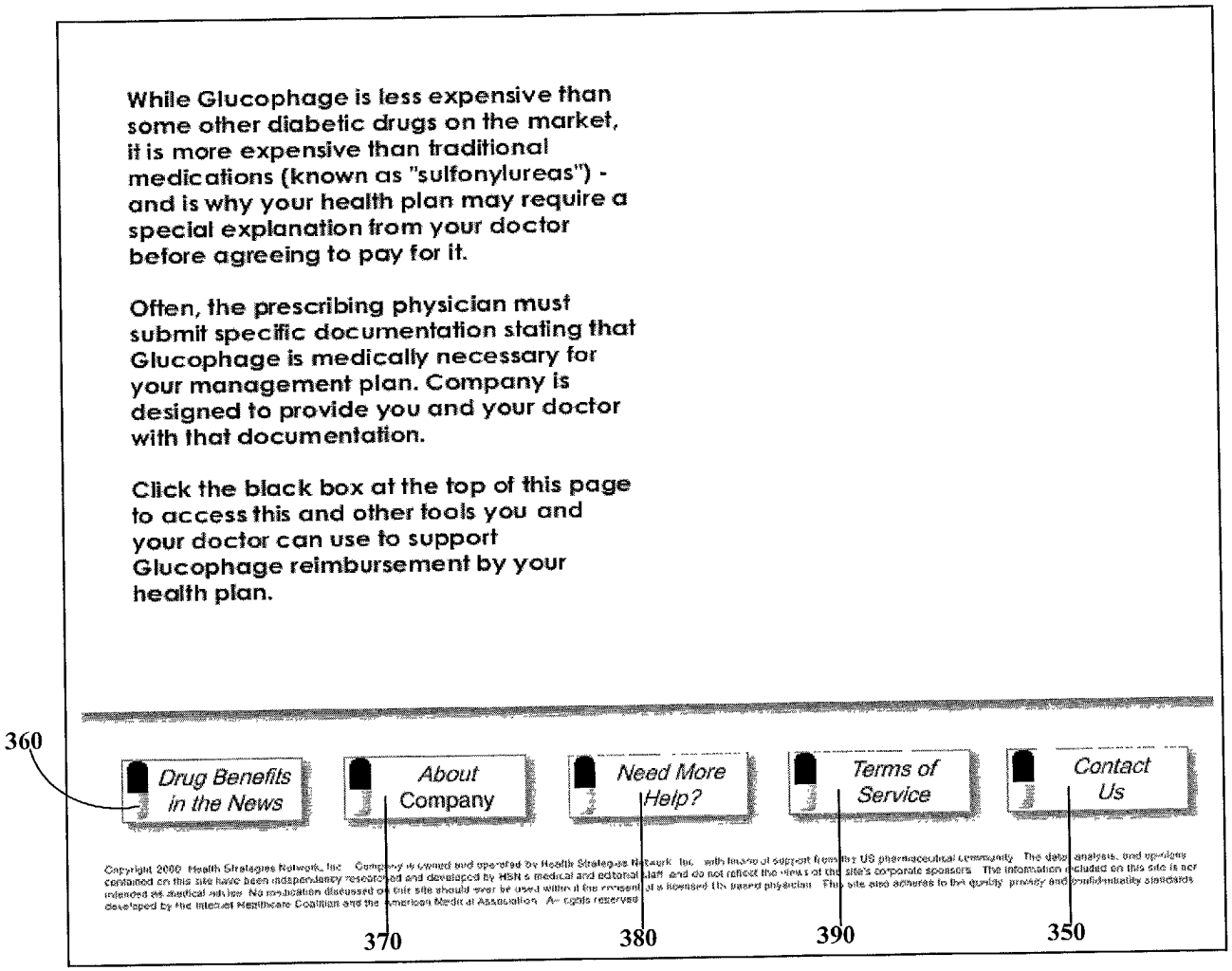


Fig. 5C

600

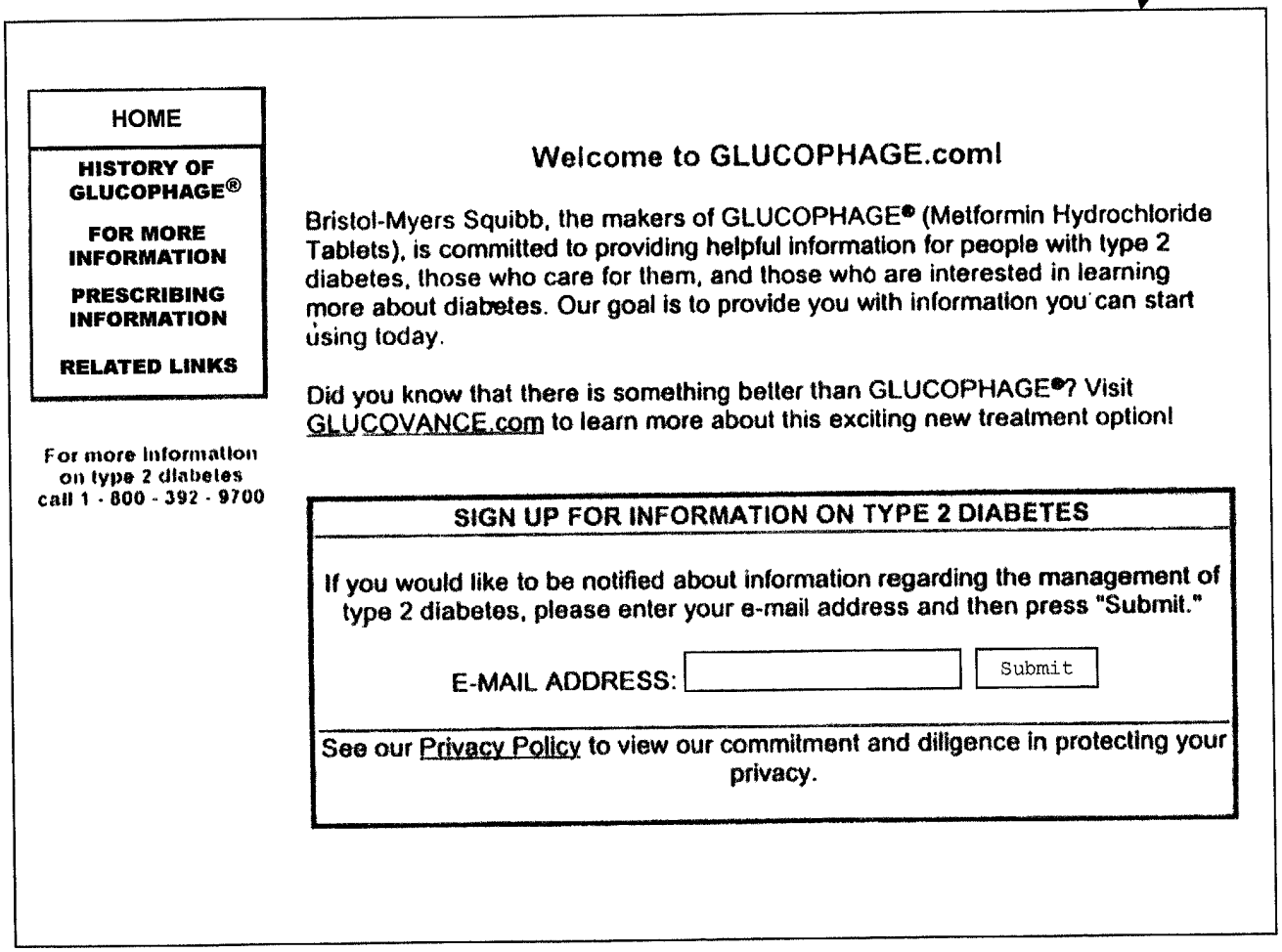

HOME
HISTORY OF GLUCOPHAGE®
FOR MORE INFORMATION
PRESCRIBING INFORMATION
RELATED LINKS
For more information on type 2 diabetes call 1 - 800 - 392 - 9700
Welcome to GLUCOPHAGE.com!
Bristol-Myers Squibb, the makers of GLUCOPHAGE® (Metformin Hydrochloride Tablets), is committed to providing helpful information for people with type 2 diabetes, those who care for them, and those who are interested in learning more about diabetes. Our goal is to provide you with information you can start using today.
Did you know that there is something better than GLUCOPHAGE®? Visit GLUCOVANCE.com to learn more about this exciting new treatment option!
SIGN UP FOR INFORMATION ON TYPE 2 DIABETES
If you would like to be notified about information regarding the management of type 2 diabetes, please enter your e-mail address and then press "Submit."
E-MAIL ADDRESS:
Submit
See our Privacy Policy to view our commitment and diligence in protecting your privacy.

Fig. 6A

600

IMPORTANT SAFETY INFORMATION ABOUT GLUCOPHAGE AND GLUCOVANCE

Glucophage and Glucovance are not for everyone. In rare cases, Glucophage or Glucovance may cause lactic acidosis. If it occurs it can be fatal in up to half of the cases. Lactic acidosis occurs mainly in people whose kidneys are not functioning properly. You should not take these drugs if: you have kidney problems, are 80 or older (unless you have your kidneys tested first), are taking medication for heart failure, are seriously dehydrated, have a severe infection, have a history of liver disease or drink alcohol excessively.

The most common side effects are diarrhea, nausea, and upset stomach. Symptoms of hypoglycemia (low blood sugar), such as lightheadedness, dizziness, shakiness, or hunger may occur.

GLUCOVANCE™ is a trademark of LIPHA s.a. GLUCOPHAGE® is a registered trademark of LIPHA s.a. Licensed to Bristol-Myers Squibb Company.

MEDWATCH, 1-800-332-1088, is available to report any serious adverse events for any drug.

Your use of the information on this site is subject to the terms and conditions of our Legal Policy.

Fig. 6B

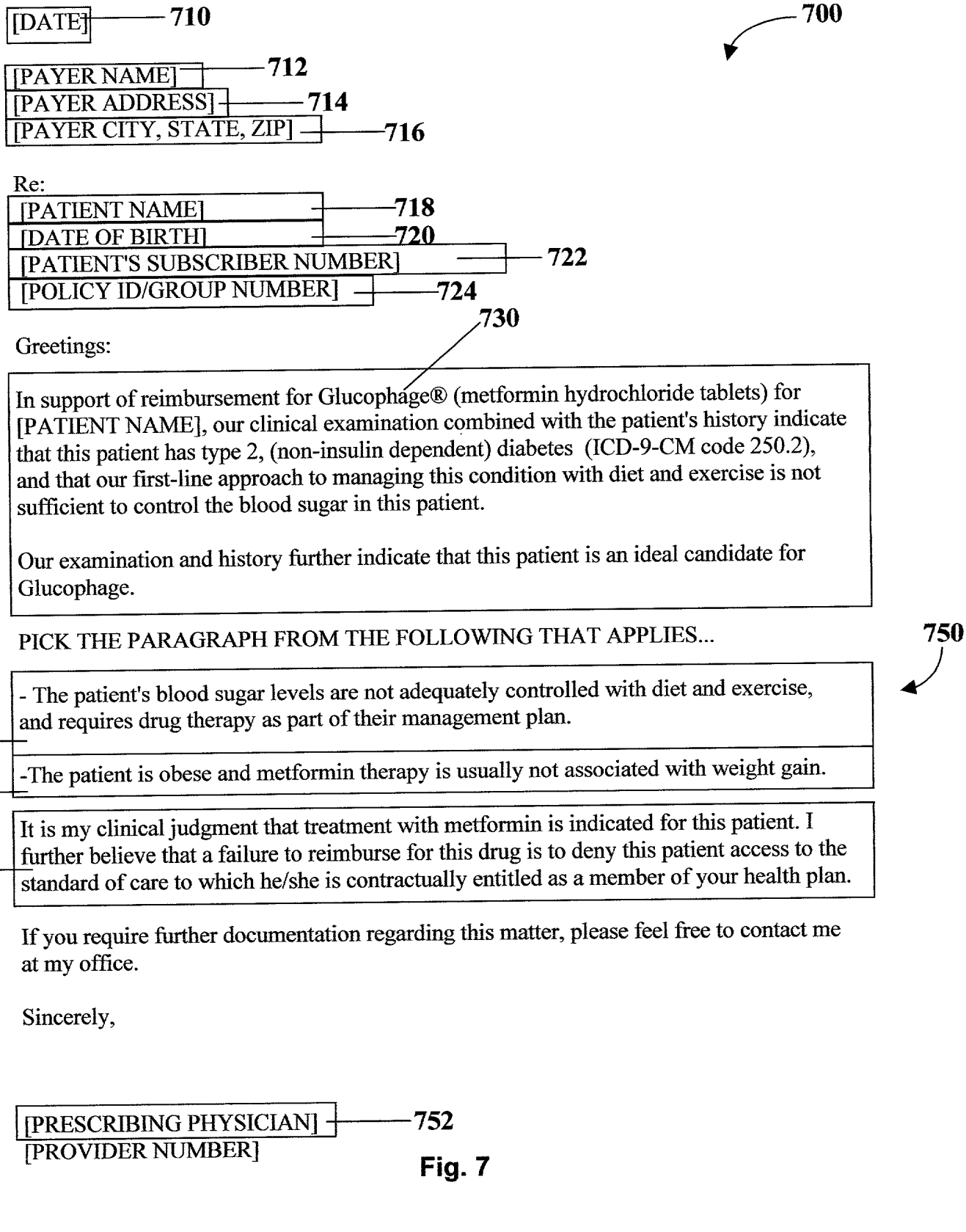
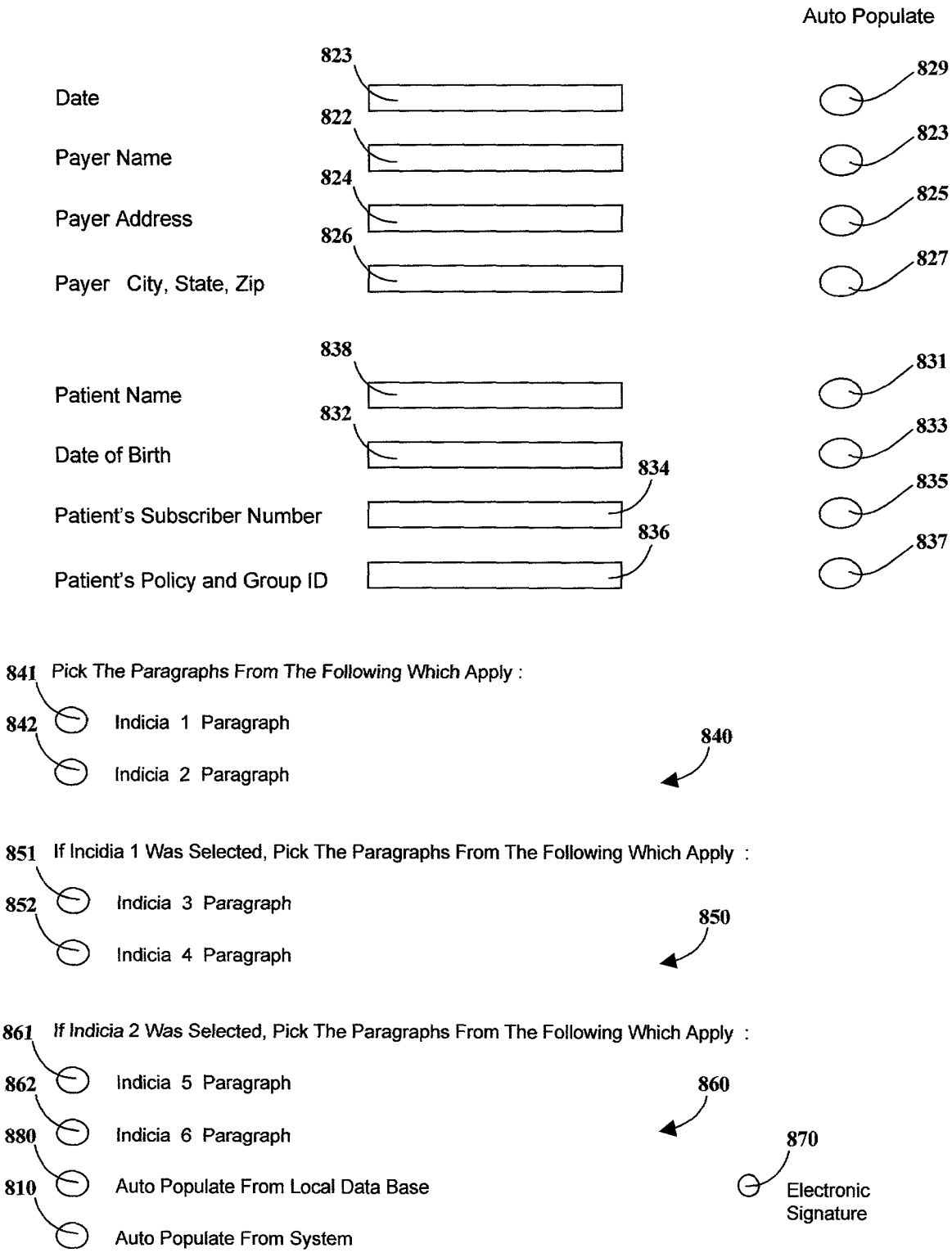

[DATE]
710
700
[PAYER NAME]
712
[PAYER ADDRESS]
714
[PAYER CITY, STATE, ZIP]
716
Re:
[PATIENT NAME]
718
[DATE OF BIRTH]
720
[PATIENT'S SUBSCRIBER NUMBER]
722
[POLICY ID/GROUP NUMBER]
724
730
Greetings:
In support of reimbursement for Glucophage® (metformin hydrochloride tablets) for [PATIENT NAME], our clinical examination combined with the patient's history indicate that this patient has type 2, (non-insulin dependent) diabetes (ICD-9-CM code 250.2), and that our first-line approach to managing this condition with diet and exercise is not sufficient to control the blood sugar in this patient.
Our examination and history further indicate that this patient is an ideal candidate for Glucophage.
PICK THE PARAGRAPH FROM THE FOLLOWING THAT APPLIES...
750
- The patient's blood sugar levels are not adequately controlled with diet and exercise, and requires drug therapy as part of their management plan.
742
-The patient is obese and metformin therapy is usually not associated with weight gain.
744
It is my clinical judgment that treatment with metformin is indicated for this patient. I further believe that a failure to reimburse for this drug is to deny this patient access to the standard of care to which he/she is contractually entitled as a member of your health plan.
750
If you require further documentation regarding this matter, please feel free to contact me at my office.
Sincerely,
[PRESCRIBING PHYSICIAN]
752
[PROVIDER NUMBER]

Fig. 7


Auto Populate
Date
Payer Name
Payer Address
Payer City, State, Zip
Patient Name
Date of Birth
Patient's Subscriber Number
Patient's Policy and Group ID
823
822
824
826
838
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833
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841 Pick The Paragraphs From The Following Which Apply :
842 Indicia 1 Paragraph
Indicia 2 Paragraph
840
851 If Incidia 1 Was Selected, Pick The Paragraphs From The Following Which Apply :
852 Indicia 3 Paragraph
Indicia 4 Paragraph
850
861 If Indicia 2 Was Selected, Pick The Paragraphs From The Following Which Apply :
862 Indicia 5 Paragraph
880 Indicia 6 Paragraph
810 Auto Populate From Local Data Base
Auto Populate From System
860
870
Electronic Signature

Fig. 8

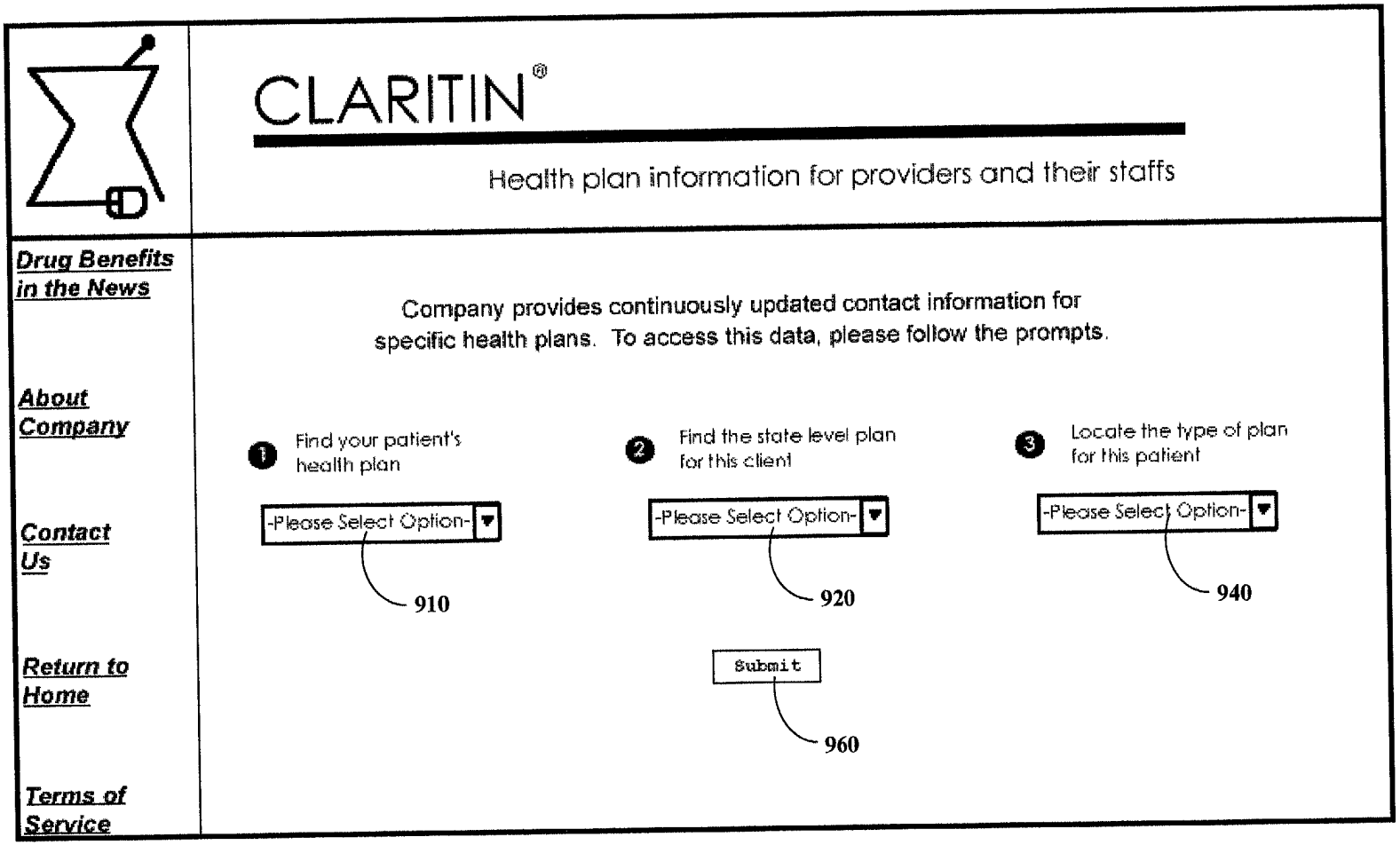

Fig. 9

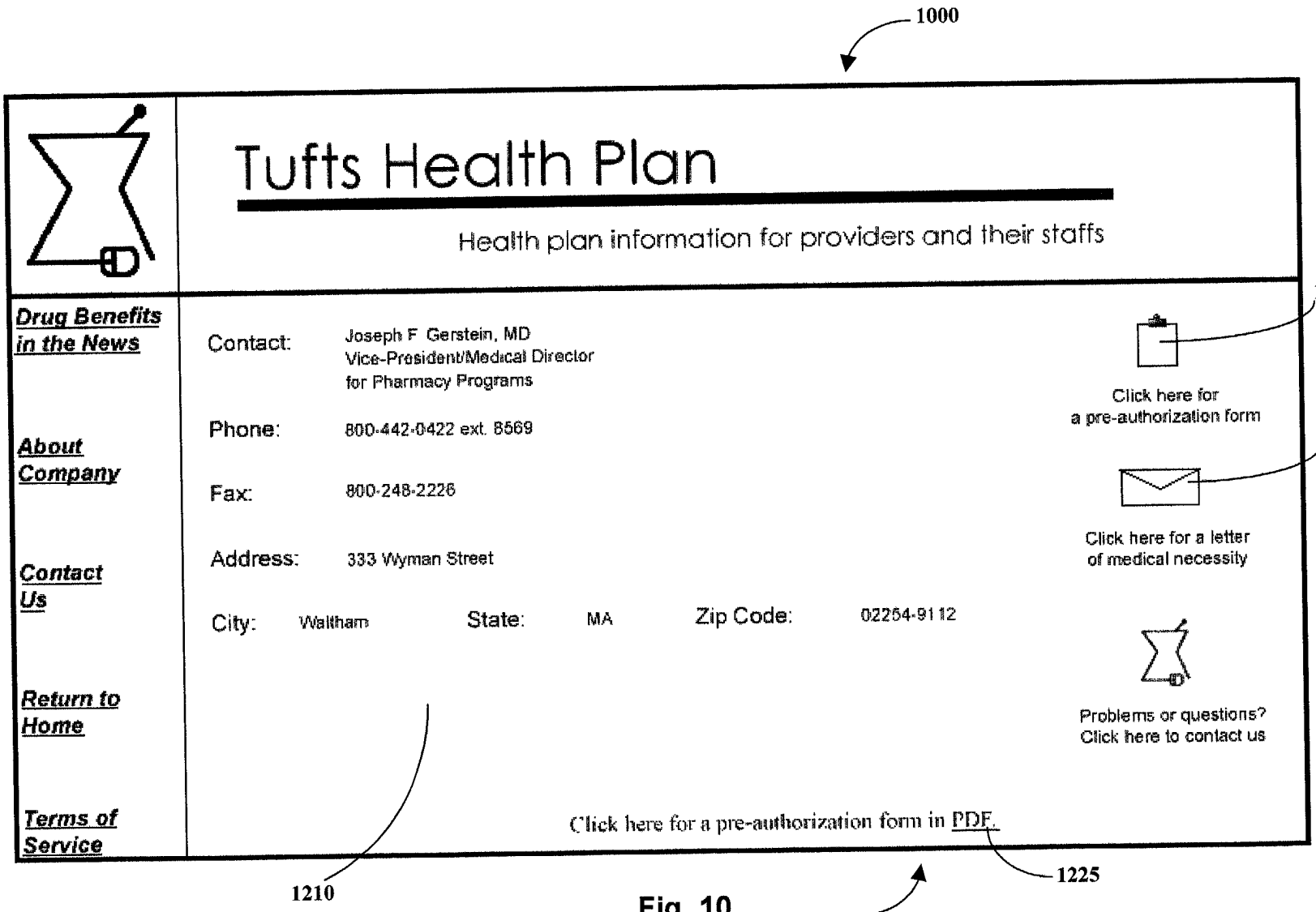
1000
Tufts Health Plan
Health plan information for providers and their staffs
Drug Benefits in the News
About Company
Contact Us
Return to Home
Terms of Service
Contact:
Joseph F Gerstein, MD
Vice-President/Medical Director
for Pharmacy Programs
Phone:
800-442-0422 ext. 8569
Fax:
800-248-2226
Address:
333 Wyman Street
City:
Waltham
State:
MA
Zip Code:
02254-9112
1020
Click here for
a pre-authorization form
1030
Click here for a letter
of medical necessity
Problems or questions?
Click here to contact us
Click here for a pre-authorization form in PDF.
1210
1225
1000

Fig. 10

TUFTS Health Plan

SecureHorizons
TUFTS Health Plan for Seniors

UNIVERSAL PHARMACY MEDICAL EXCEPTION REQUEST FORM

1100 This medical exception request form should be used for all drug products which have restrictions, such as drugs in the Pre-Authorization Program, the Dispensing Limitations Program, non-covered drugs under the Prescription Alternative Program and for New-to-Market drug products for which a coverage determination has yet to be made by Tufts Health Plan.

1110 **PLEASE PHOTOCOPY THIS FORM FOR FUTURE REQUESTS**
PLEASE TYPE OR PRINT LEGIBLY

I. MEMBER INFORMATION: Tufts HP Use Only: Date Rec'd

NAME: _____
DOB: Date of Request:

1120 Tufts Health Plan/Secure Horizons Member ID# _____ (suffix)

1121 **II. PRESCRIBER INFORMATION:**

Prescriber is: [☐ PCP] [☐ Specialist (specify)_____] Other (specify)

1122 **Prescriber:** Name:_____
1123 Address: _____
1124 Telephone: (___) _____
1125 Fax Number: (___) _____
1130 1126 Office Contact Person to answer questions:_____

III. PRESCRIBER REQUEST: Request coverage for or increased quantity of:

Name of drug:_____
Strength of drug:_____
Form of drug (e.g. tablet, injectable, nasal spray, topical, etc.):_____
Requested frequency of drug: [☐ once/day] [☐ twice/day] [☐ three times/day]
[☐ four times/day] [☐ once/week] [☐ once/month] [☐ other (specify)_____]

Anticipated length of therapy: _____days _____weeks _____months
(Number of days/weeks/months) _____maintenance _____other (specify)

Fig. 11a

1100

Pertinent patient primary diagnosis for which this drug is indicated (no codes):

_____

Pertinent co-morbid diagnoses (no codes): 1._____ 2. _____

Pertinent drugs member is currently taking:

1. _____ 2. _____ 3. _____

Page 2

Alternative drugs which failed	PL currently on med? (Y/N)	Reason(s) for failure
1.		1.
2.		2.
3.		3.

In the space provided below, please indicate any other information relevant to this patient that indicates the efficacy of the requested product for the condition in question (i.e. lab data, clinical outcomes, patient symptoms, etc.). Please refer to the guidelines for additional information.

_____

_____

1140 _____

_____

_____

IV. DRUGS WITH ADDITIONAL INFORMATION REQUIRED:

Lamisil (tablets) /Sporanox (capsules) (check all that apply)

***Sporanox is not preferred and will be authorized in special circumstances only.**

Limited to nail surface ☐ **YES** ☐ **NO** ☐ Paronychia ☐ Peripheral Vascular Disease

☐ Systemic Fungus (specify):_____ ☐ Immune Deficiency (specify):_____

Injectable Drugs for Multiple Sclerosis (check applicable box below)

***Enclose letter or consult note from Neurologist* - REQUIRED**

☐ Relapsing-Remitting MS ☐ Secondary-Progressive MS

☐ Primary-Progressive MS ☐ Progressive-Relapsing MS

1150 **Anti-Obesity Medications**

_____Height **(in.)** in stocking feet Weight (lbs.) in exam gown BMI

1160 **PRESCRIBER SIGNTURE:**_____ **DATE:**_____

(REQUIRED)

SEND OR FAX COMPLETED FORM TO: Tufts Health Plan/Policy Department
PO Box 9112
Waltham, MA 02451-9112
FAX (781) 466-9095

Fig. 11b

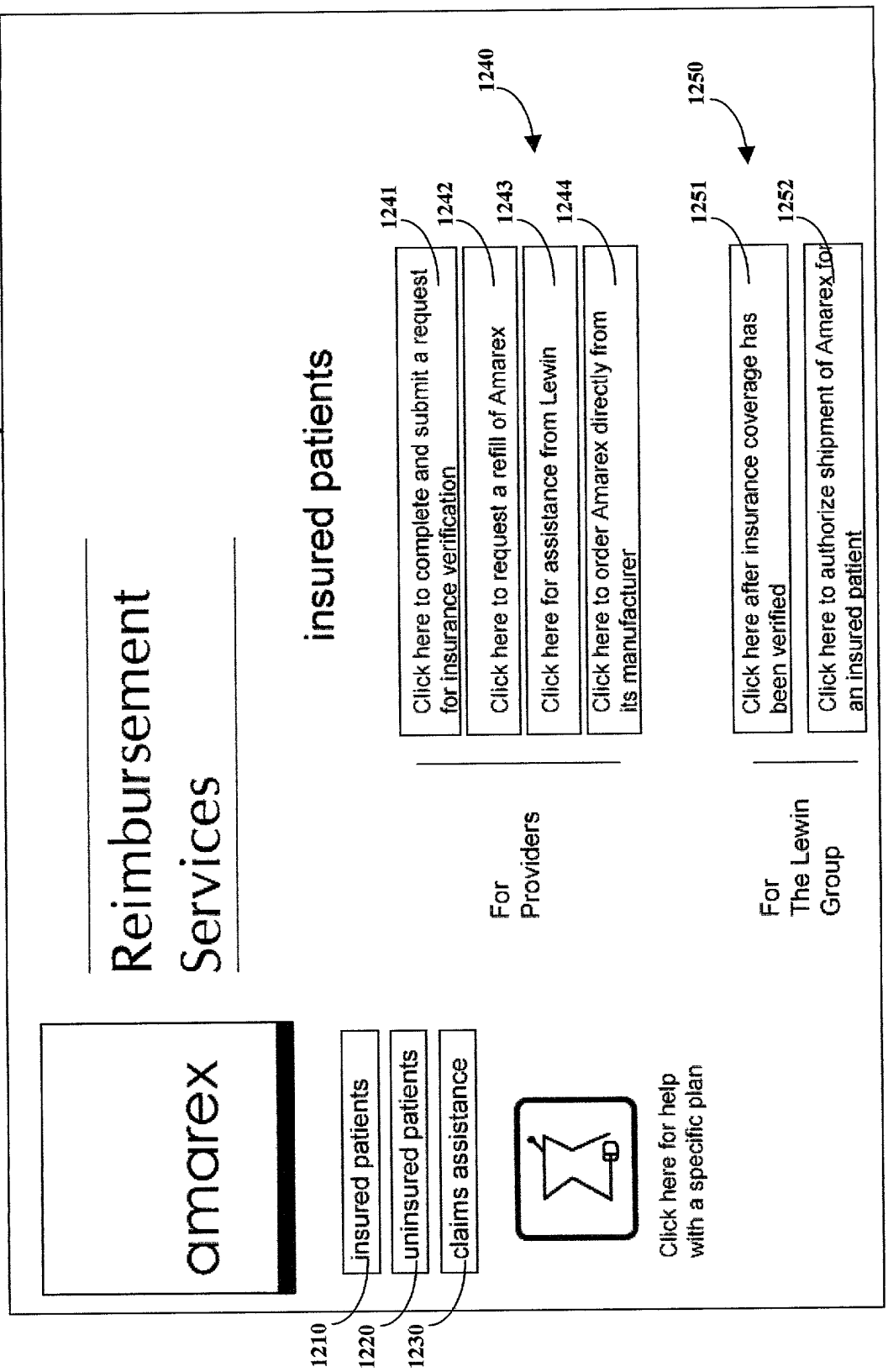
1200
amarex
Reimbursement Services
insured patients
uninsured patients
claims assistance
Click here for help with a specific plan
1210
1220
1230
For Providers
1240
1241
Click here to complete and submit a request for insurance verification
1242
Click here to request a refill of Amarex
1243
Click here for assistance from Lewin
1244
Click here to order Amarex directly from its manufacturer
For The Lewin Group
1250
1251
Click here after insurance coverage has been verified
1252
Click here to authorize shipment of Amarex for an insured patient

Fig. 12

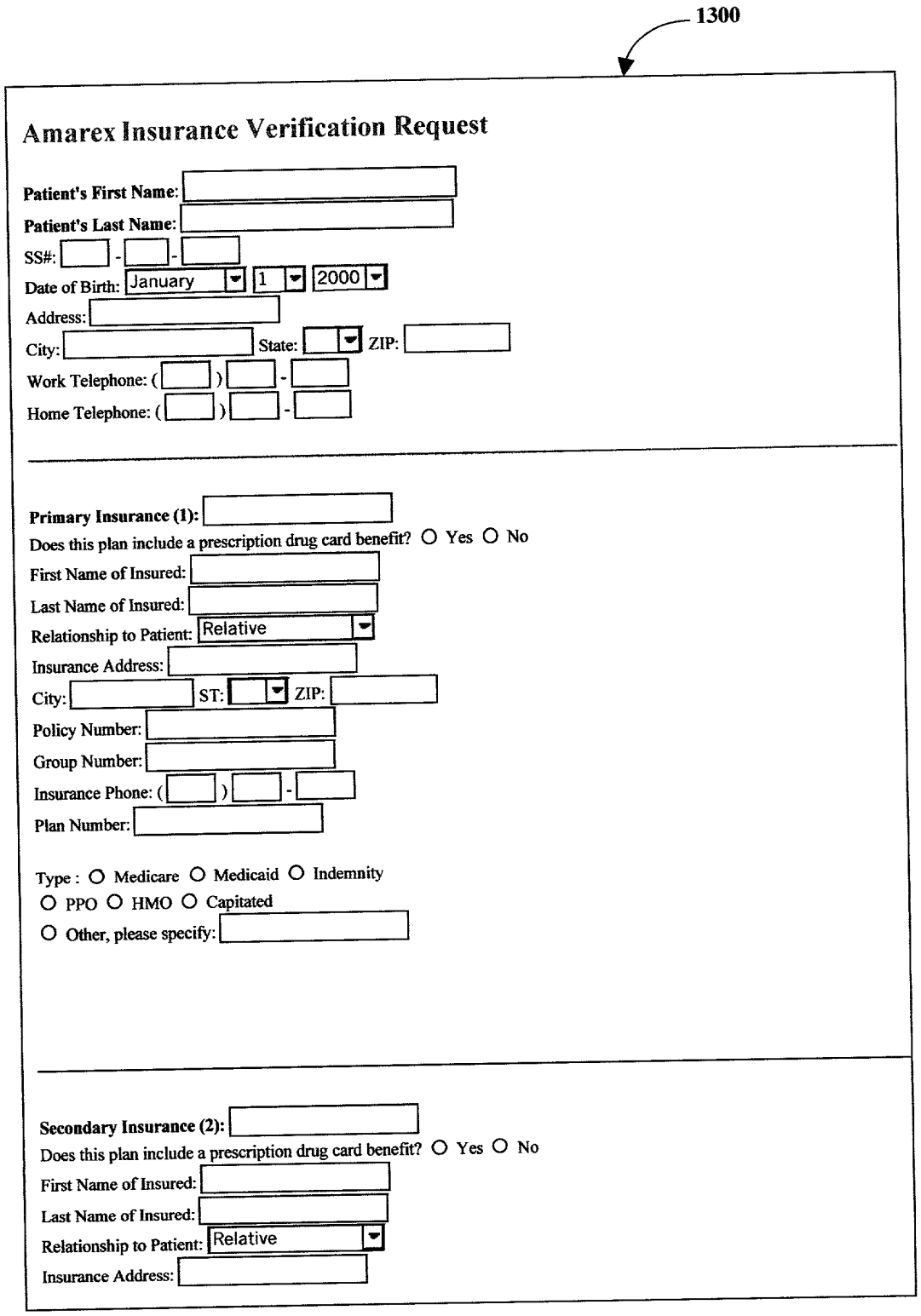
1300
Amarex Insurance Verification Request
Patient's First Name:
Patient's Last Name:
SS#:
Date of Birth: January 1 2000
Address:
City: State: ZIP:
Work Telephone: ( ) -
Home Telephone: ( ) -
Primary Insurance (1):
Does this plan include a prescription drug card benefit? Yes No
First Name of Insured:
Last Name of Insured:
Relationship to Patient: Relative
Insurance Address:
City: ST: ZIP:
Policy Number:
Group Number:
Insurance Phone: ( ) -
Plan Number:
Type : Medicare Medicaid Indemnity
PPO HMO Capitated
Other, please specify:
Secondary Insurance (2):
Does this plan include a prescription drug card benefit? Yes No
First Name of Insured:
Last Name of Insured:
Relationship to Patient: Relative
Insurance Address:

Fig. 13A

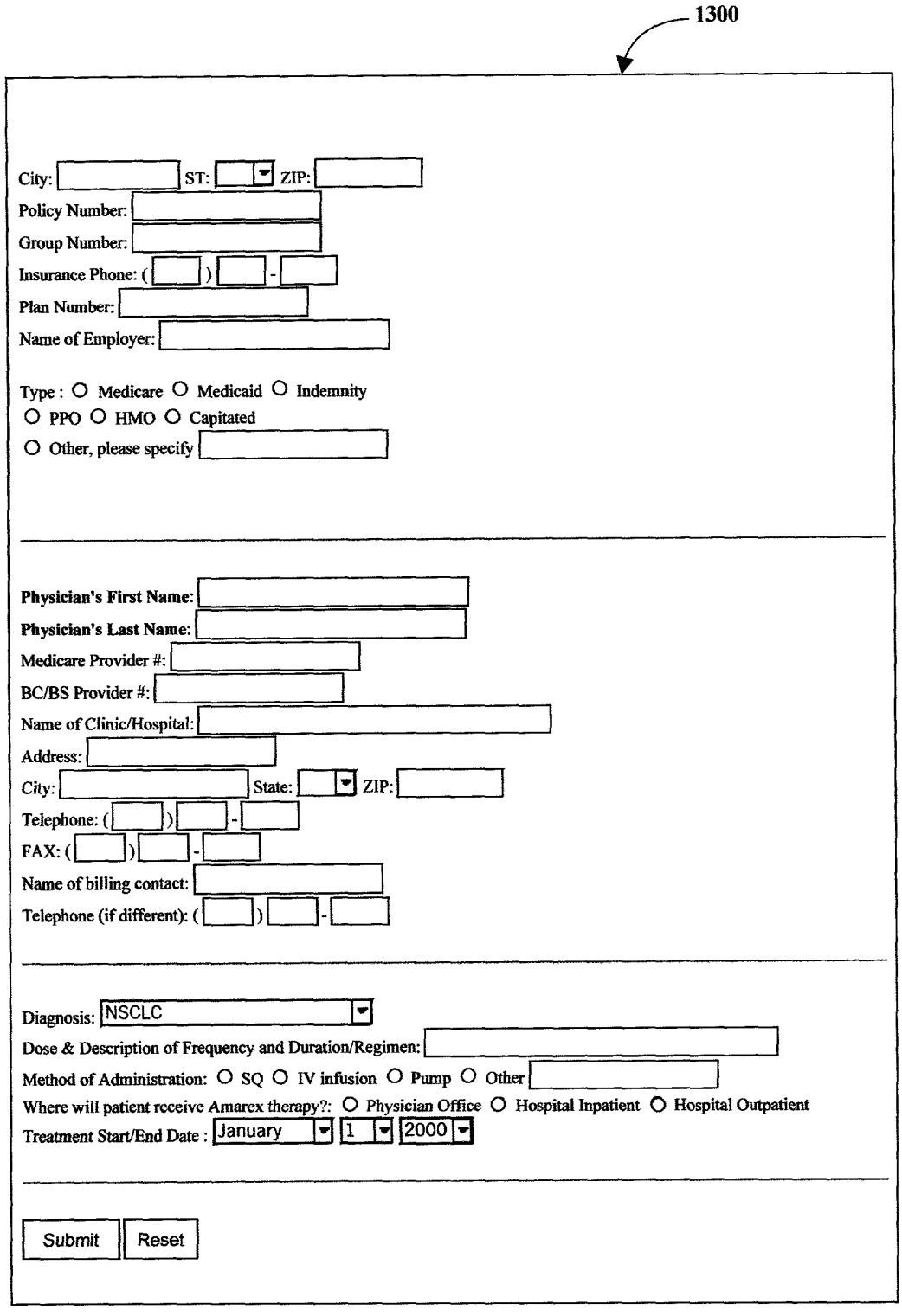
1300
City: ST: ZIP:
Policy Number:
Group Number:
Insurance Phone: ( ) -
Plan Number:
Name of Employer:
Type : O Medicare O Medicaid O Indemnity
O PPO O HMO O Capitated
O Other, please specify
Physician's First Name:
Physician's Last Name:
Medicare Provider #:
BC/BS Provider #:
Name of Clinic/Hospital:
Address:
City: State: ZIP:
Telephone: ( ) -
FAX: ( ) -
Name of billing contact:
Telephone (if different): ( ) -
Diagnosis: NSCLC
Dose & Description of Frequency and Duration/Regimen:
Method of Administration: O SQ O IV infusion O Pump O Other
Where will patient receive Amarex therapy?: O Physician Office O Hospital Inpatient O Hospital Outpatient
Treatment Start/End Date : January 1 2000
Submit
Reset

Fig. 13B

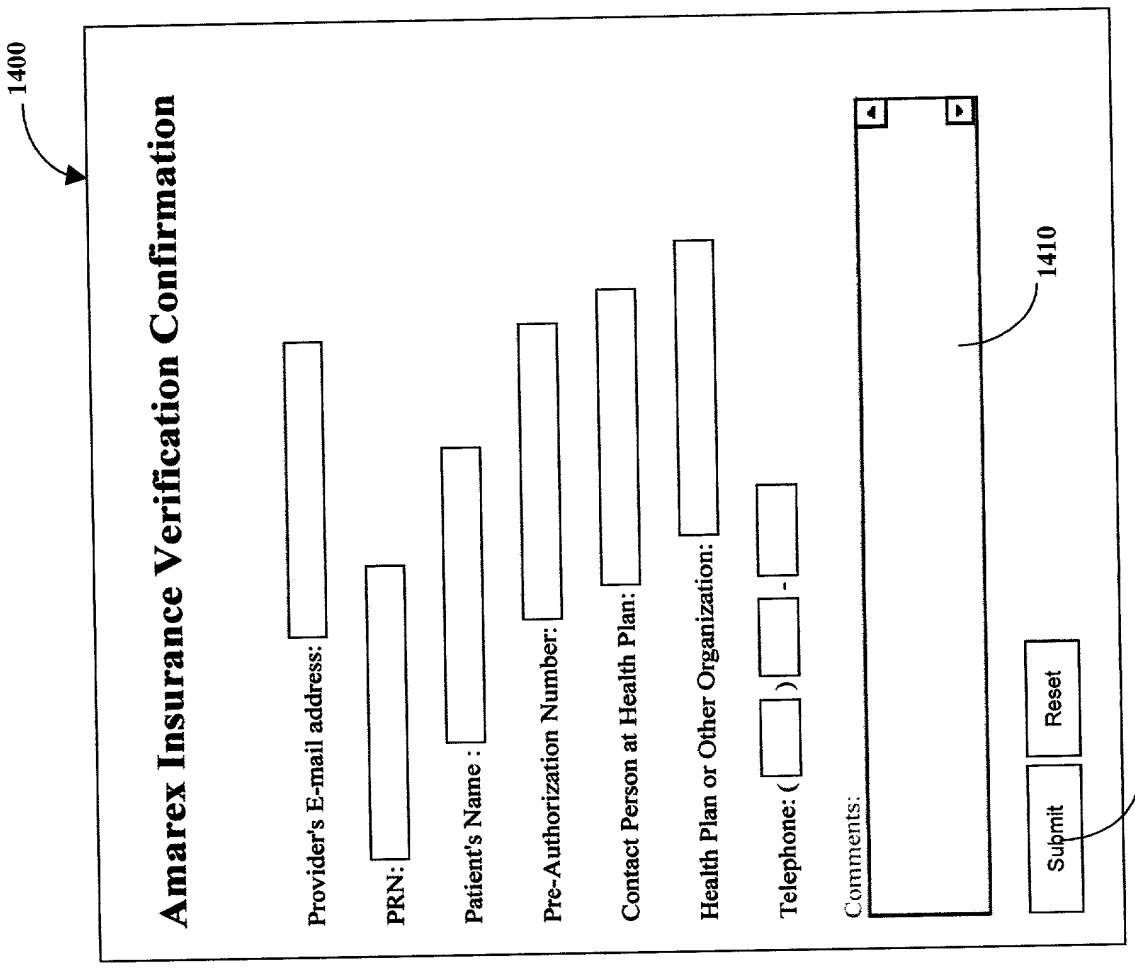
1400
Amarex Insurance Verification Confirmation
Provider's E-mail address:
PRN:
Patient's Name :
Pre-Authorization Number:
Contact Person at Health Plan:
Health Plan or Other Organization:
Telephone: ( ) -
Comments:
1410
Submit
Reset
1420

Fig.14

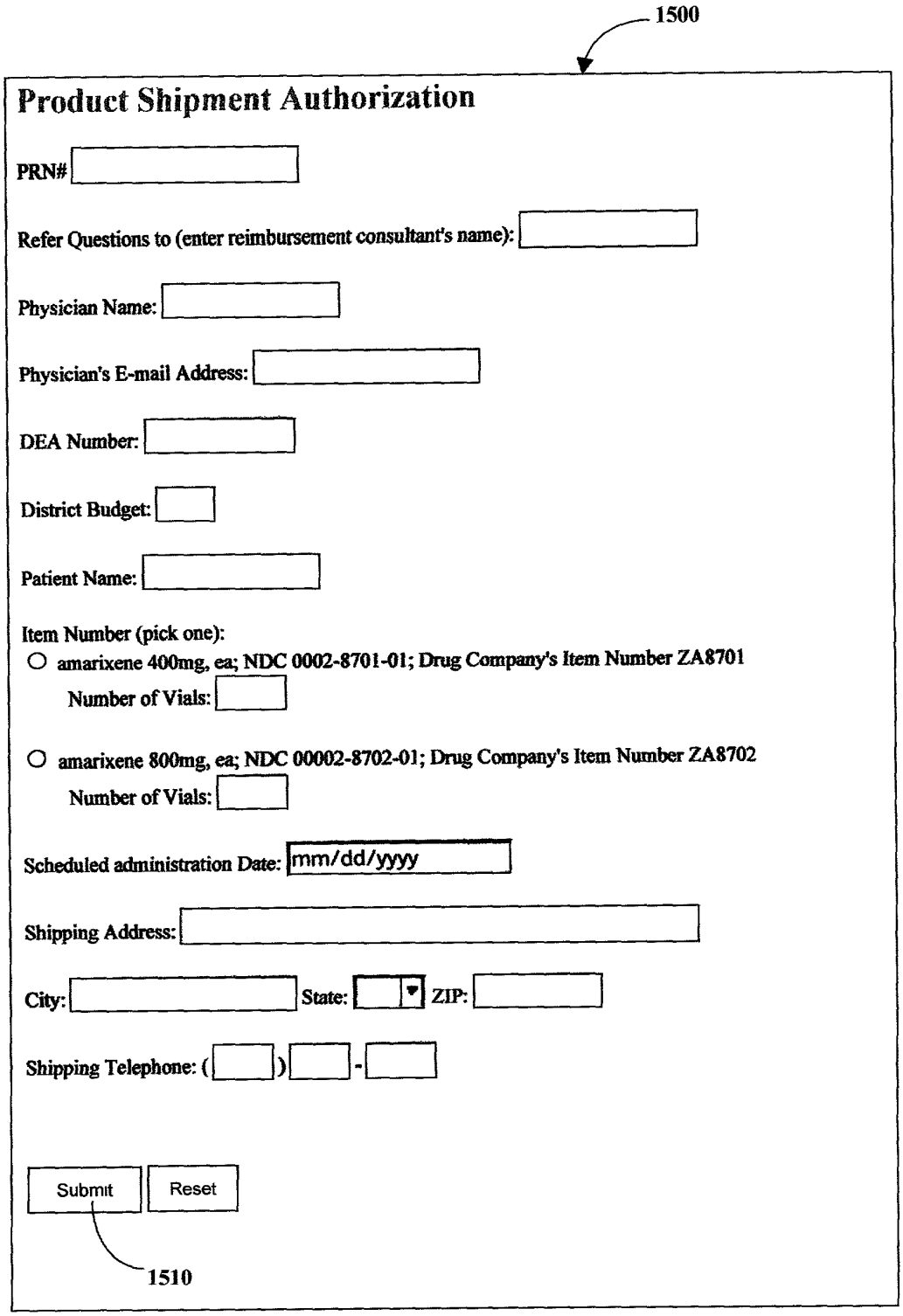
1500
Product Shipment Authorization
PRN#
Refer Questions to (enter reimbursement consultant's name):
Physician Name:
Physician's E-mail Address:
DEA Number:
District Budget:
Patient Name:
Item Number (pick one):
amarixene 400mg, ea; NDC 0002-8701-01; Drug Company's Item Number ZA8701
Number of Vials:
amarixene 800mg, ea; NDC 00002-8702-01; Drug Company's Item Number ZA8702
Number of Vials:
Scheduled administration Date: mm/dd/yyyy
Shipping Address:
City:
State:
ZIP:
Shipping Telephone: ( ) -
Submit
Reset
1510

Fig. 15

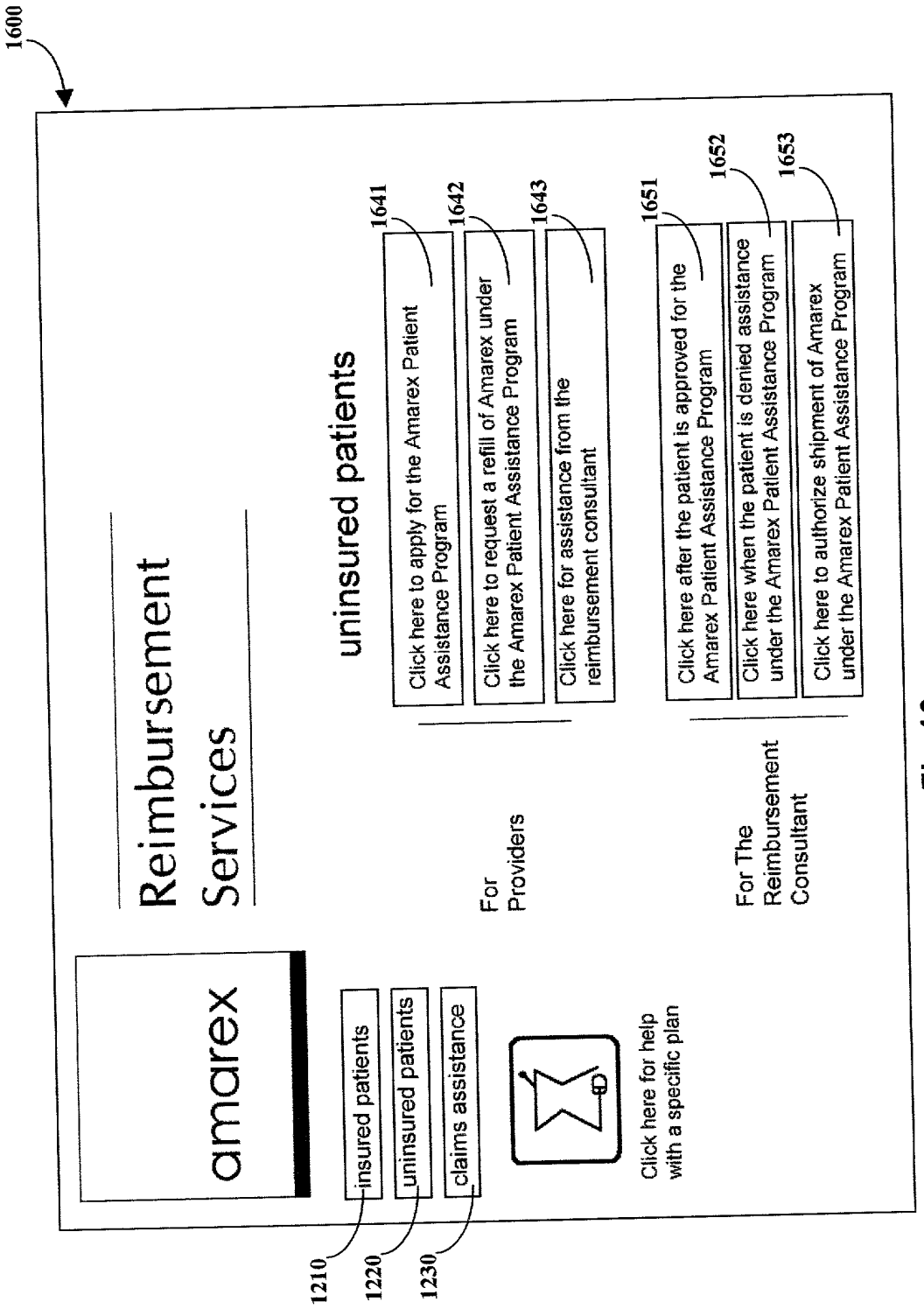
1600
amarex
Reimbursement Services
insured patients
uninsured patients
claims assistance
1210
1220
1230
Click here for help with a specific plan
For Providers
uninsured patients
Click here to apply for the Amarex Patient Assistance Program
Click here to request a refill of Amarex under the Amarex Patient Assistance Program
Click here for assistance from the reimbursement consultant
1641
1642
1643
For The Reimbursement Consultant
Click here after the patient is approved for the Amarex Patient Assistance Program
Click here when the patient is denied assistance under the Amarex Patient Assistance Program
Click here to authorize shipment of Amarex under the Amarex Patient Assistance Program
1651
1652
1653

Fig.16

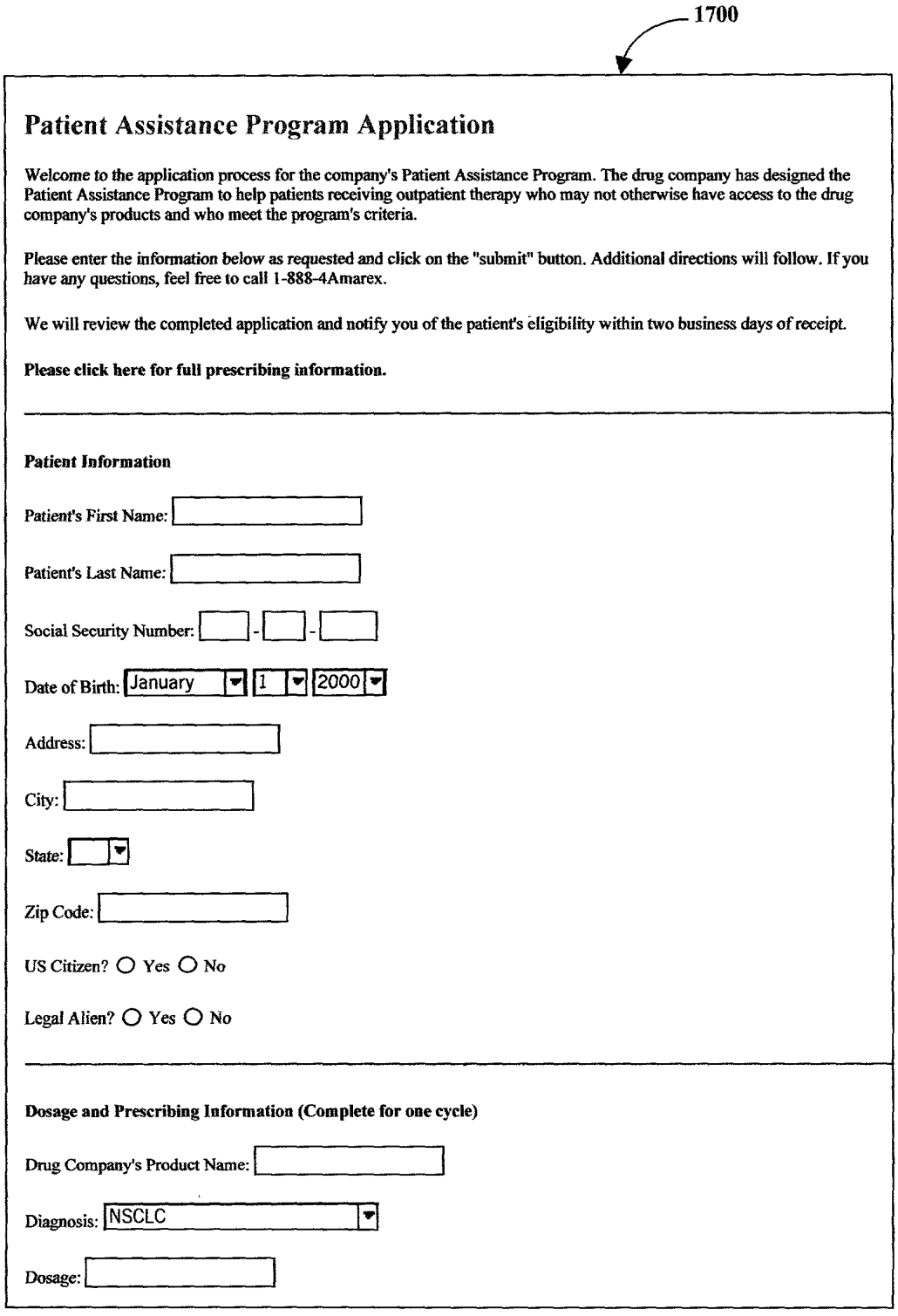
1700
Patient Assistance Program Application
Welcome to the application process for the company's Patient Assistance Program. The drug company has designed the Patient Assistance Program to help patients receiving outpatient therapy who may not otherwise have access to the drug company's products and who meet the program's criteria.
Please enter the information below as requested and click on the "submit" button. Additional directions will follow. If you have any questions, feel free to call 1-888-4Amarex.
We will review the completed application and notify you of the patient's eligibility within two business days of receipt.
Please click here for full prescribing information.
Patient Information
Patient's First Name:
Patient's Last Name:
Social Security Number: - -
Date of Birth: January 1 2000
Address:
City:
State:
Zip Code:
US Citizen? Yes No
Legal Alien? Yes No
Dosage and Prescribing Information (Complete for one cycle)
Drug Company's Product Name:
Diagnosis: NSCLC
Dosage:

Fig. 17A

1700

Patient Size: [ ] m2

mg/Infusion: [ ] mg

Number of Weeks in Cycle: [ ]

Insurance Information
(check all that apply)

	Has Benefits	Application Pending	Not Eligible	Has Not Applied
Medicaid	O	O	O	O
Other State Medical Assistance	O	O	O	O
Medicare	O	O	O	O
Private Insurance	O	O	O	O
Employer Insurance	O	O	O	O
Federal (FEHB, VA, CHAMPUS)	O	O	O	O
Other: [ ]	O	O	O	O

Insurance Company Name: [ ]

Address Line 1: [ ]

Address Line 2: [ ]

City: [ ] State: [ ] ZIP: [ ]

Telephone Number: ([ ]) [ ] - [ ]

Policyholder Name: [ ]

Patient Relationship to Policyholder: [Relative]

Policy Number: [ ]

Group Number: [ ]

Fig. 17B

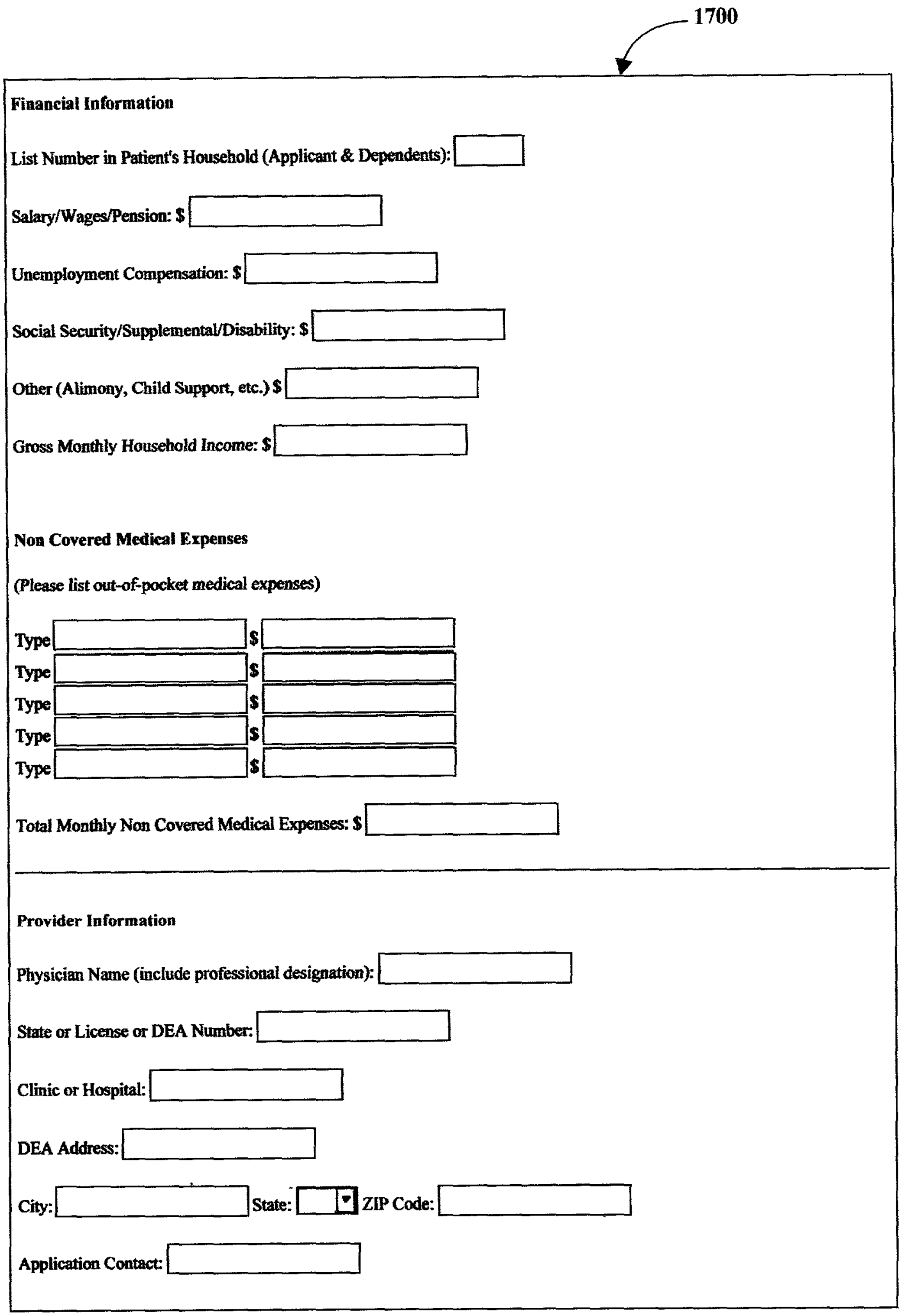
1700
Financial Information
List Number in Patient's Household (Applicant & Dependents):
Salary/Wages/Pension: $
Unemployment Compensation: $
Social Security/Supplemental/Disability: $
Other (Alimony, Child Support, etc.) $
Gross Monthly Household Income: $
Non Covered Medical Expenses
(Please list out-of-pocket medical expenses)
Type $
Type $
Type $
Type $
Type $
Total Monthly Non Covered Medical Expenses: $
Provider Information
Physician Name (include professional designation):
State or License or DEA Number:
Clinic or Hospital:
DEA Address:
City: State: ZIP Code:
Application Contact:

Fig. 17C

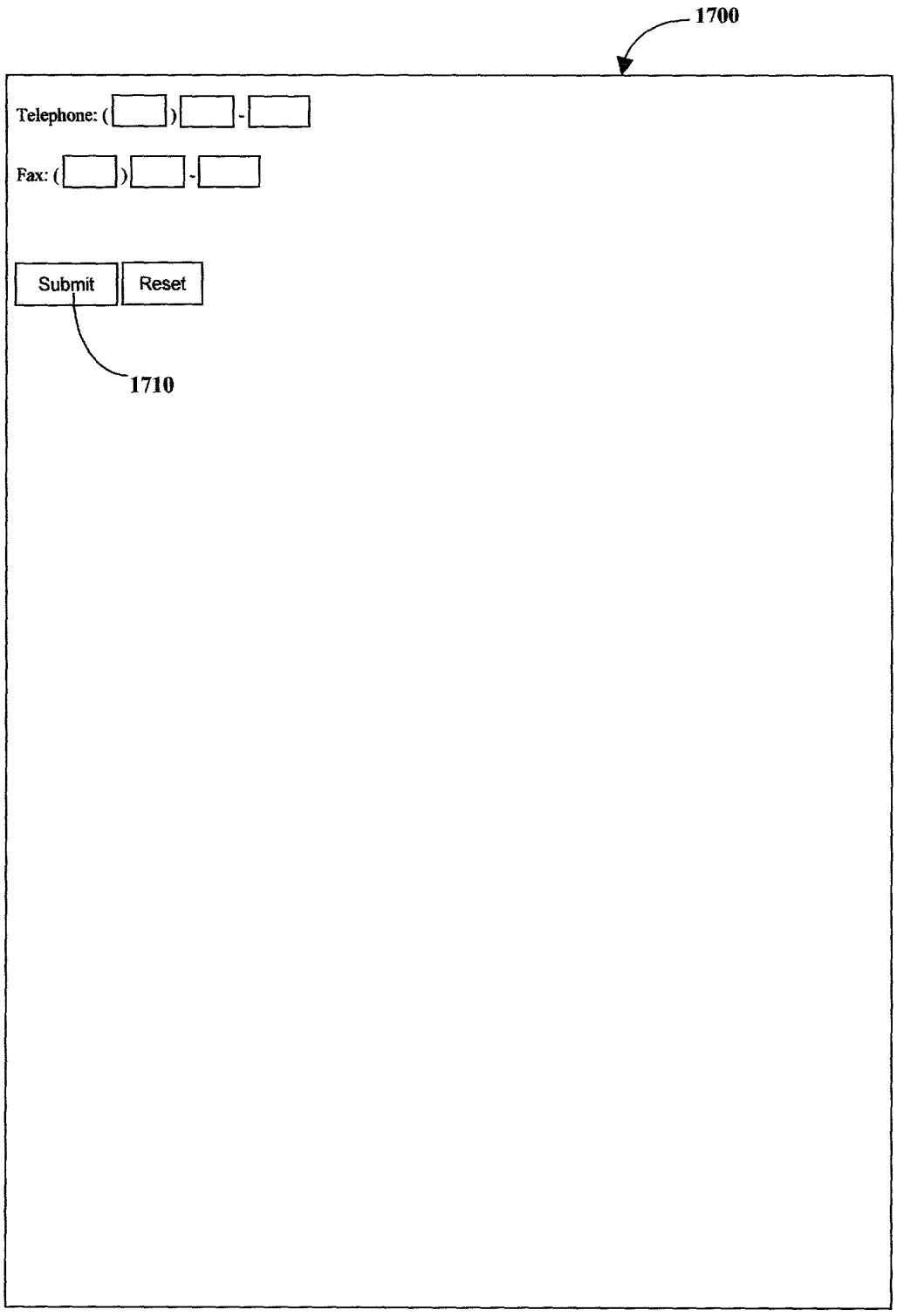

Fig. 17D

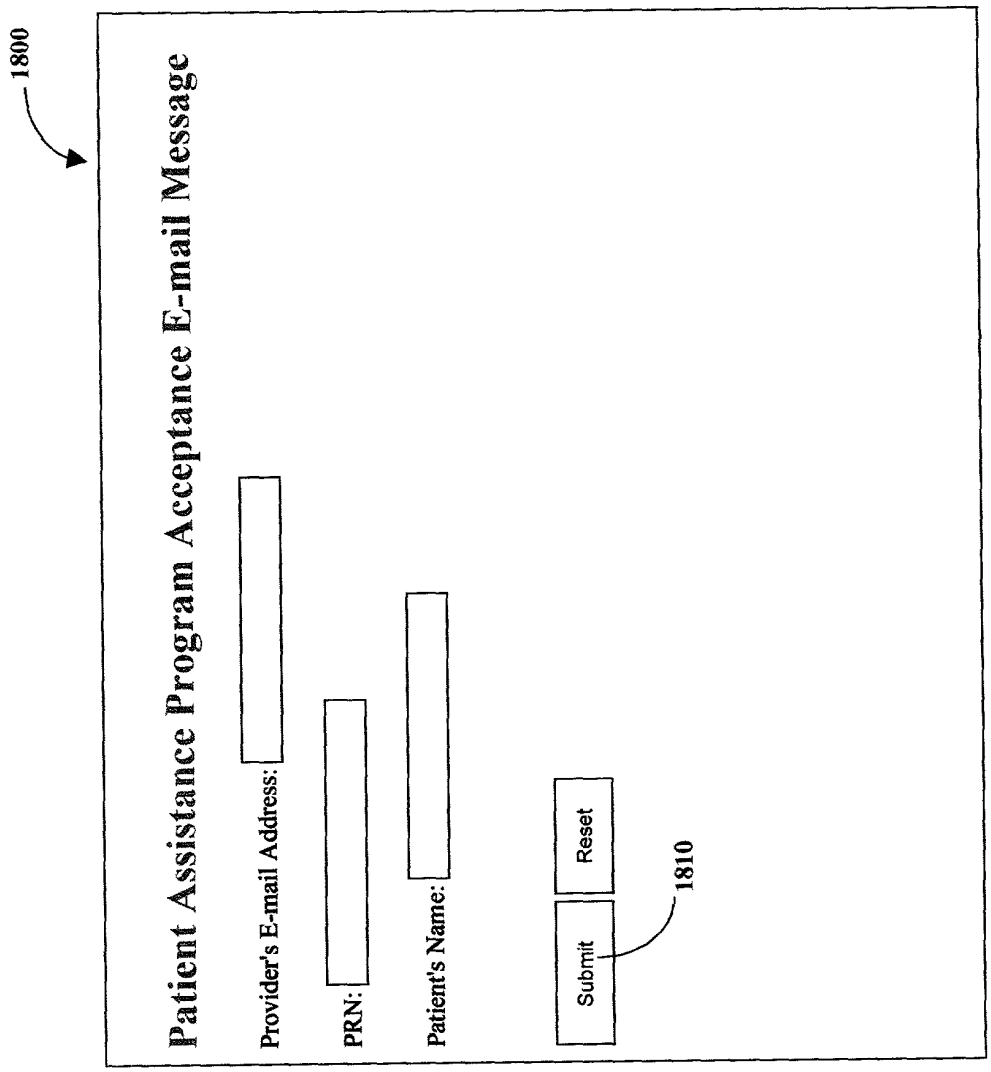
1800
Patient Assistance Program Acceptance E-mail Message
Provider's E-mail Address:
PRN:
Patient's Name:
Submit
Reset
1810

Fig.18

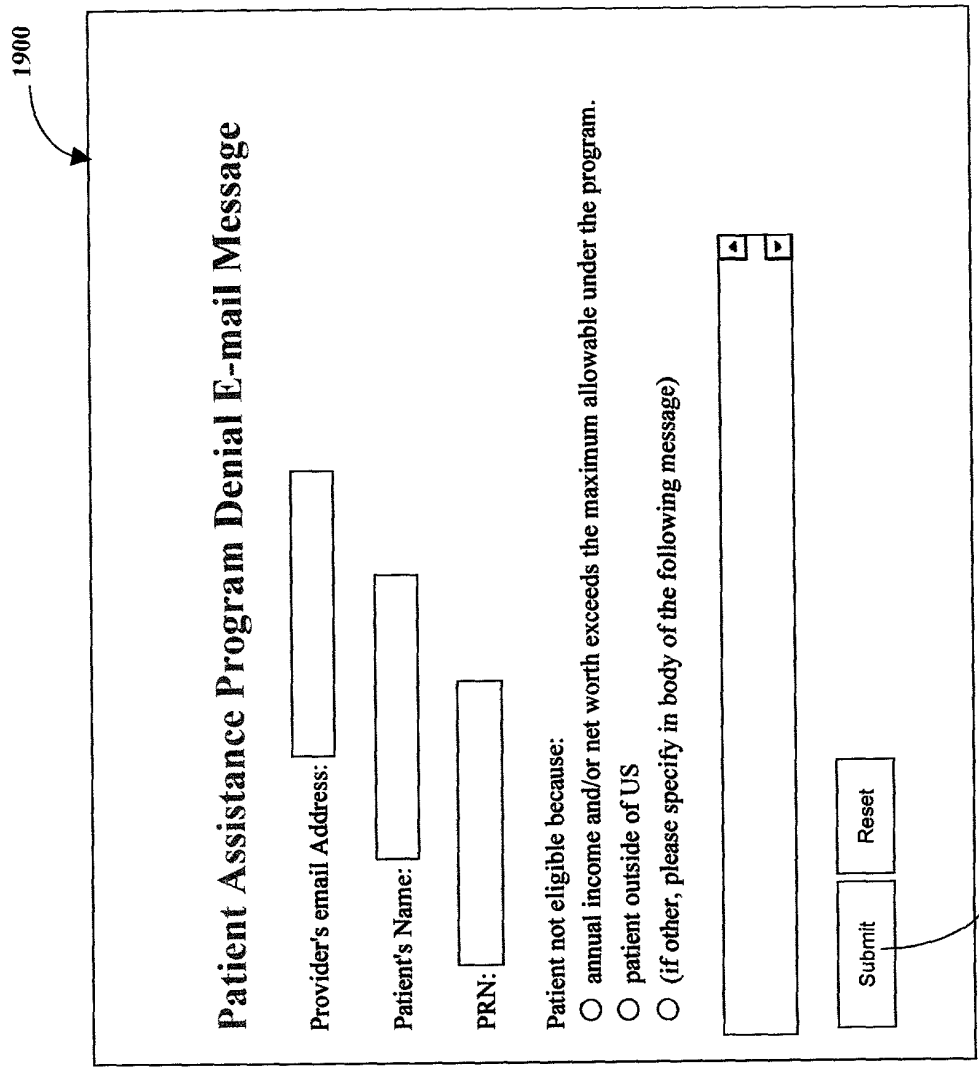
1900
Patient Assistance Program Denial E-mail Message
Provider's email Address:
Patient's Name:
PRN:
Patient not eligible because:
annual income and/or net worth exceeds the maximum allowable under the program.
patient outside of US
(if other, please specify in body of the following message)
Submit
Reset
1910

Fig.19

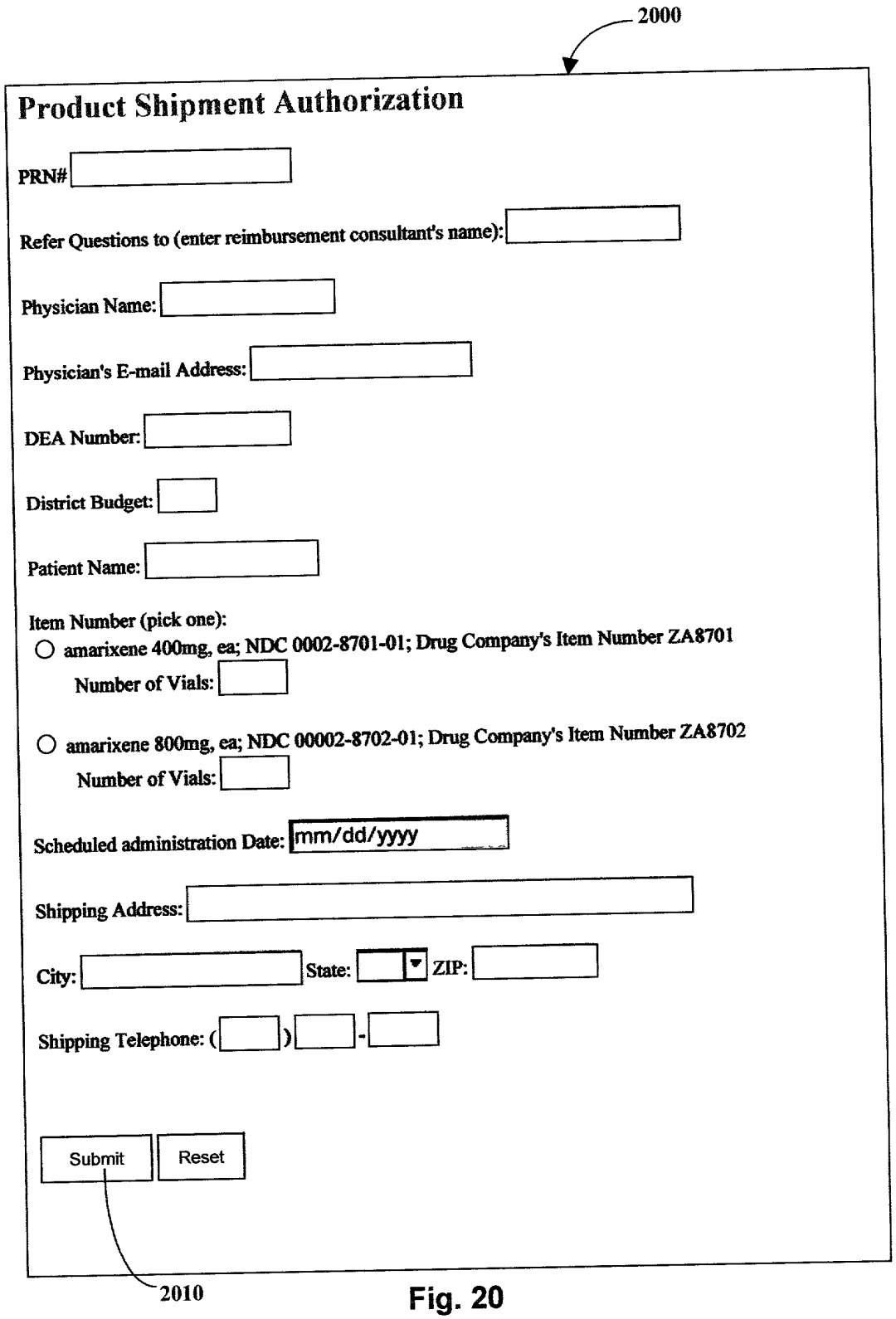
2000
Product Shipment Authorization
PRN#
Refer Questions to (enter reimbursement consultant's name):
Physician Name:
Physician's E-mail Address:
DEA Number:
District Budget:
Patient Name:
Item Number (pick one):
amarixene 400mg, ea; NDC 0002-8701-01; Drug Company's Item Number ZA8701
Number of Vials:
amarixene 800mg, ea; NDC 00002-8702-01; Drug Company's Item Number ZA8702
Number of Vials:
Scheduled administration Date: mm/dd/yyyy
Shipping Address:
City:
State:
ZIP:
Shipping Telephone: ( ) -
Submit
Reset
2010

Fig. 20

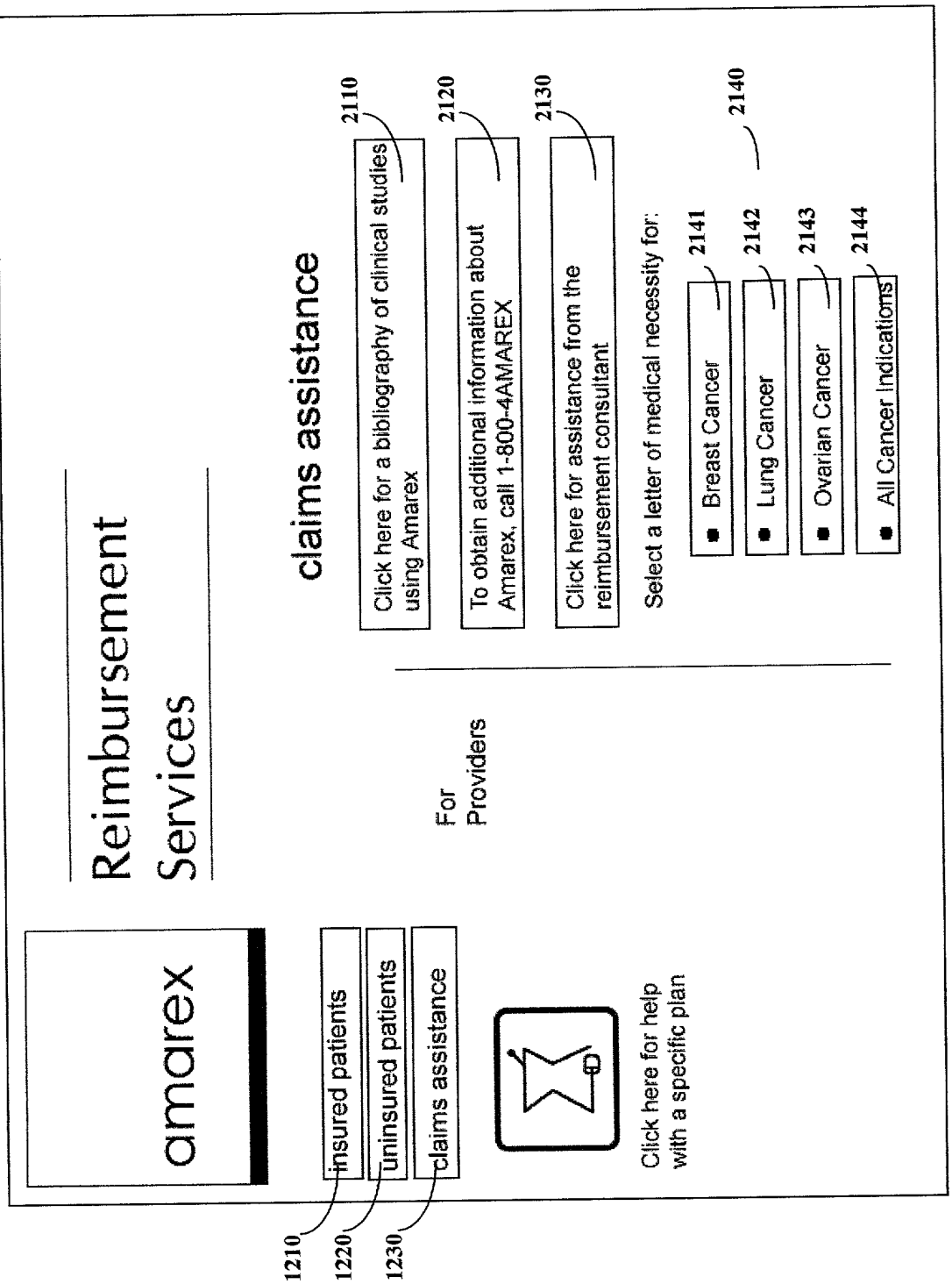
2100
amarex
Reimbursement Services
insured patients
uninsured patients
claims assistance
Click here for help with a specific plan
For Providers
claims assistance
Click here for a bibliography of clinical studies using Amarex
To obtain additional information about Amarex, call 1-800-4AMAREX
Click here for assistance from the reimbursement consultant
Select a letter of medical necessity for:
Breast Cancer
Lung Cancer
Ovarian Cancer
All Cancer Indications
1210
1220
1230
2110
2120
2130
2140
2141
2142
2143
2144

Fig. 21

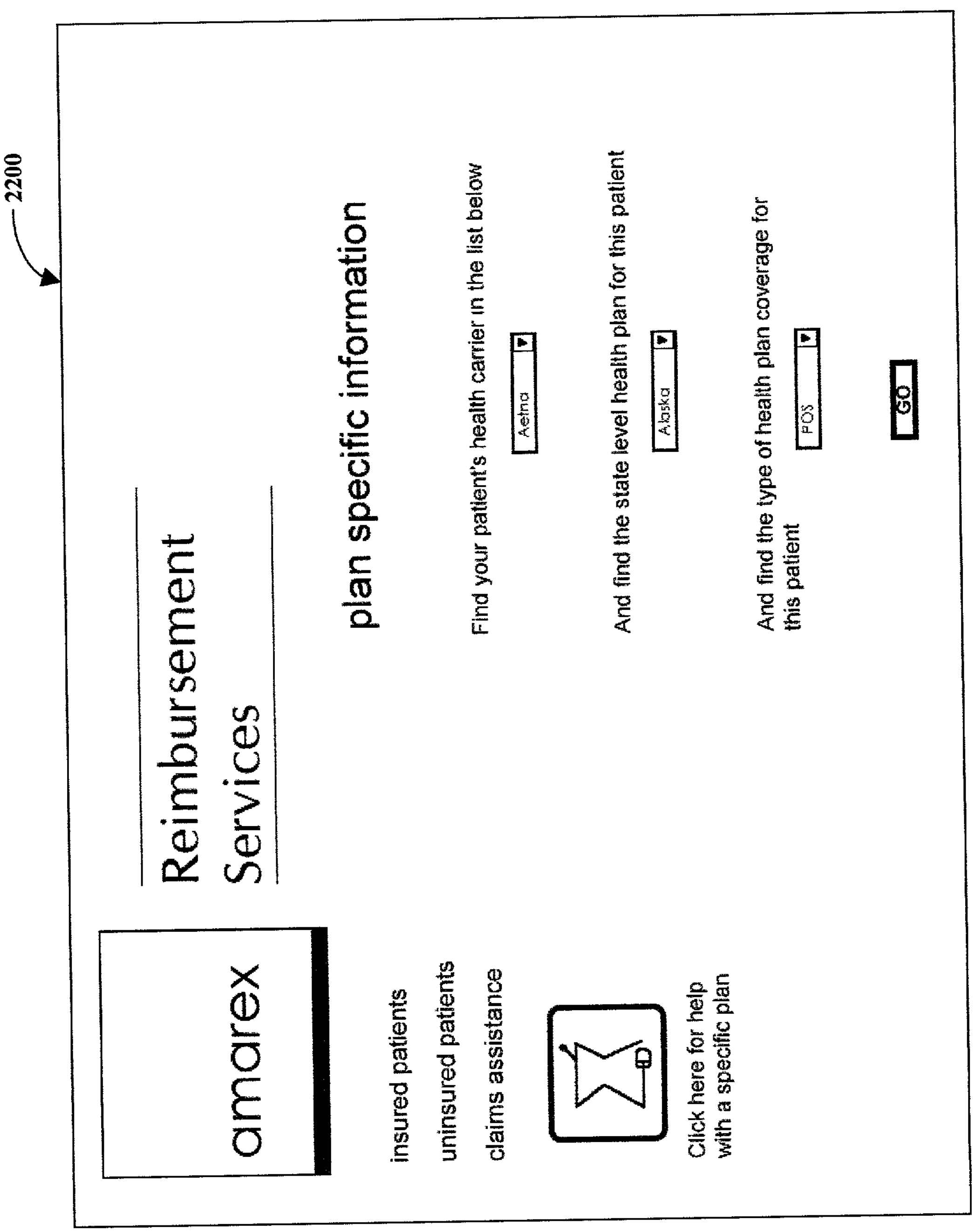
2200
amarex
Reimbursement
Services
plan specific information
insured patients
uninsured patients
claims assistance
Click here for help
with a specific plan
Find your patient's health carrier in the list below
Aetna
And find the state level health plan for this patient
Alaska
And find the type of health plan coverage for
this patient
POS
GO

Fig. 22